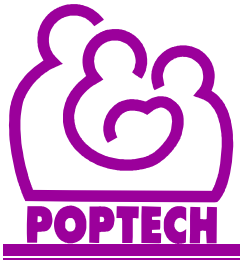

EVALUATION

OF

PRIME II

Judith Fullerton
Nancy J. Piet-Pelon
William Trayfors
Sandra Wilcox

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The Population Technical Assistance Project
1101 Vermont Avenue, NW, Suite 900
Washington, DC 20005
Telephone: (202) 898-9040
Fax: (202) 898-9057
admin@poptechproject.com

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ACRONYMS AND ABBREVIATIONS

ACNM	American College of Nurse-Midwives
ADOPLAFAM	Asociación Dominicana de Planificación Familiar
CA	Cooperating agency
CHPS	Community-based Health Planning and Services (Ghana)
COPE®	Client-oriented, provider-efficient services (EngenderHealth)
CTO	Cognizant technical officer
DFID	Department for International Development (United Kingdom)
ECSACON	East, Central and Southern African College of Nursing
FP	Family planning
FY	Fiscal year
GHS	Ghana Health Services
GRMA	Ghana Registered Midwives Association
GTZ	German Technical Cooperation
HIV/AIDS	Human immunodeficiency virus/acquired immune deficiency syndrome
HPSP	Health and Population Sector Program
INTRAH	Program for International Training in Health
IPPF	International Planned Parenthood Federation
IR	Intermediate Result
IUD	Intrauterine device
MAARD	Modified Acquisition and Assistance Request Document
MOH	Ministry of Health
NGO	Nongovernmental organization
NIPHP	National Integrated Health and Population Program
PAC	Postabortion care
PAQ	Partenariat pour l'amelioration de la Qualité
PATH	Program for Appropriate Technology in Health
POPTECH	Population Technical Assistance Project
PROSAF	Integrated Family Health Program
PSI	Population Services International
RH	Reproductive health
STI	Sexually transmitted infection
TBA	Traditional birth attendant
TRG	Training Resources Group
UNC	University of North Carolina
UNFPA	United Nations Population Fund
URC	University Research Co., LLC
USAID	United States Agency for International Development
WHO	World Health Organization

CONTENTS

Page

Executive Summary i

I. Introduction and Background 1
- Introduction 1
- Background 2
- Scope of Work 3
- Organization of the Report 3

II. Strengthened Preservice Education, Inservice Training, and Continuing Education Systems (IR 1) 4
- Strengthening Education and Training Systems 4
- Performance Needs Assessments 6
- Learning Approaches Developed, Tested, and Used for Primary and Nontraditional Providers 8
- Use of Information Technology 10
- Building Organizational Capacity To Develop Training Curricula 12
- Training Sites Established 13
- Linkages for Provider Mentoring Among Professional Schools, Associations, and Service Delivery Sites 15
- Improvement of Management Support Systems 16
- Monitoring and Evaluation of Provider Performance 17

III. Improved Management Support Systems (IR 2) 21
- Use of Performance Improvement in Strengthening Management Systems 21
- Performance Improvement Challenges and Lessons Learned 22

IV. Improved Policy Environment (IR 3) 23
- Improved National Standards, Guidelines, Norms, and Protocols for Service Delivery and Preservice Education 23
- Improved Policy Development, Dissemination, and Implementation 23
- Assurance of Informed Choice in Family Planning and Reproductive Health Projects 25

V. Better Informed and Empowered Clients and Communities (IR 4) 27
- Strategies Used to Inform and Empower Clients and Communities 27
- Challenges Faced in Engaging Clients 28
- Ensuring FP/RH Clients Make Informed Decisions About Their Fertility 30

VI. Management
- Leadership, Management, and Partnership 31
  - Structure of IntraHealth and the Impact on PRIME II's Mission 31
  - USAID Management of PRIME II: Strengths and Challenges 31
  - IntraHealth's Performance as Lead Agency on PRIME II 32
  - Involvement of Other Partners in PRIME II 33
  - Benefits and Challenges of the Consortium Partnership 34

Benefits and Challenges of Regional Offices....35
Staff Recruiting and Retention in PRIME II....35
Working With PRIME II: Experiences of Partners, USAID, and Others....35
Greatest Challenges Faced in Implementing PRIME II....36
Project Costs....37
Funding Trends Over the Life of the Project....37
Yearly Increases in Field Support Funding....38
Value Added by Use of Core Funding....39
Cost-Containment Approaches....41
Programming....43
Implementation of the Four Technical Leadership Areas To Achieve the IRs....43
Rationale for the Revision of the Technical Leadership Areas....43
Ensuring Complementarity of PRIME II Approaches....44

VII. Future Directions....46
Components of PRIME II To Be Preserved for the Future....46
Recommended Changes to Management Interface Between PRIME and USAID....48

TABLE

Summary of PRIME II Funding to Date....39

FIGURES

1. Actual Obligations by Type....37
2. Field Support/MAARD Actual Obligations by Account....38

APPENDICES

A. Scope of Work
B. Persons Contacted
C. Mission Responses
D. Country Summaries
E. PRIME II Self-Assessment Questions
F. PRIME II Country Programs by Region
G. Summary of Recommendations
H. Performance Factors by Project for PRIME II
I. Summary of PRIME II Funding to Date
J. Examples of Expected Results from Continued PRIME II Work
K. References

EXECUTIVE SUMMARY

BACKGROUND

The purpose of this evaluation was to assess the performance of PRIME II and to provide guidance to USAID regarding the design of future projects. The final evaluation was undertaken with approximately one year remaining in the cooperative agreement.

In September 2003, an evaluation team consisting of four senior professionals was assembled by the Population Technical Assistance Project (POPTECH) to conduct the evaluation. The team's skills and experience include preservice and inservice training, clinical practice, management, policy and strategic planning, information technology, measurement and evaluation, and intimate knowledge of and experience with the U. S. Agency for International Development's (USAID) organization and operations in the United States and abroad.

A standard evaluation process was followed, including

- reviewing key project documents, including a self-assessment prepared by the PRIME II staff, which detailed specific project results;
- soliciting feedback from all countries in which PRIME II has worked through an e-mail survey, to which 12 USAID Missions responded;
- conducting telephone interviews with Missions, partners, and other stakeholders;
- visiting and attending briefing meetings with USAID/Washington staff and PRIME II headquarters staff in Chapel Hill, North Carolina; and
- visiting subprojects in four countries, one each in Africa (Ghana), Asia (Bangladesh), Eastern Europe (Armenia), and Latin America (Paraguay).

THE PRIME II PROJECT DESIGN

PRIME II is implemented under a five-year cooperative agreement by IntraHealth International, Inc., and four partners: Abt Associates Inc., EngenderHealth, Program for Appropriate Technology in Health (PATH), and Training Resources Group (TRG). In addition, the project includes two associate organizations: the American College of Nurse-Midwives (ACNM) and Save the Children. PRIME II was preceded by PRIME I, which was a five-year contract.

The PRIME II agreement included a one-year base period and a four-year option period. The base period was effective beginning September 30, 1999, and was authorized at a funding level of $15,228,411. The option period was effective October 1, 2000, and ends September 30, 2004, at a funding level of $88,167,768. Funding for PRIME II through fiscal year (FY) 2003 includes the following:

Core	$30,542,000
Field Support	39,519,241 (both committed and obligated)
Total	**$70,061,241**

Strategic Objective and Intermediate Results

PRIME II contributes specifically to the **strategic objective** of the Training Results Package of the Bureau for Global Health, Office of Population and Reproductive Health, "Improved provider performance and sustainable, national systems for training and education in family planning and reproductive health."

PRIME II's **Intermediate Results** (IRs) include

- IR 1: Strengthened preservice education, inservice training, and continuing education systems
- IR 2: Improved management support systems for training
- IR 3: Improved policy environment for training
- IR 4: Better informed and empowered clients and communities

The overall goal of the cooperative agreement is to improve family planning and other reproductive health care services that primary-level service providers offer their clients. The clear focus is on **improving provider performance**, not just improving provider skills. Primary providers include all levels of service providers (i.e., those who work directly with clients in order to deliver reproductive health [RH] services, including family planning [FP], HIV/AIDS, maternal health, and postabortion care [PAC]).

PRIME II currently divides its portfolio into four **technical leadership areas**:

- responsive training and learning,
- performance improvement,
- postabortion care, and
- HIV/AIDS and family planning integration.

Desired Project Results

PRIME II was designed to improve primary provider performance by addressing key constraints to performance through targeted interventions. The project was meant to address both knowledge and skills gaps (with training and learning interventions) and other gaps in the enabling environment, such as policy and protocols, supportive supervision, and integrating consumer perspectives.

Performance Improvement Methodology

The project was designed to evolve the performance improvement approach and its potential for efficacy in a variety of low resource settings. PRIME II followed a process that usually began with stakeholders' meetings to define desired performance and

collaborative performance needs assessments to identify gaps between desired and actual performance. Project staff worked with host country ministries of health and other organizations to identify and develop interventions to close performance gaps.

While PRIME's focus is on outputs (i.e., improving provider performance by addressing key constraints to good performance), the performance improvement approach often involves work at all levels, from policy and planning to the lowest cadre of service providers. PRIME attempts to address both training/learning and nontraining issues (such as supportive supervision, logistics, supplies, and equipment).

KEY FINDINGS

- PRIME's performance under the cooperative agreement has been strong, as has that of its partner organizations (Abt, PATH, EngenderHealth, and TRG). This performance has been aided by the excellence of the PRIME partnership itself, which has been purposefully established and nourished throughout the PRIME II period. It should serve as a model for future programming.

- USAID Mission receptivity has been high, field support funding totals more than half the overall budget and has increased annually, and praise for PRIME's work has been plentiful.

- Near the outset of the fifth and final year of the cooperative agreement, PRIME is on schedule to accomplish nearly all of the items in its performance monitoring plan. Because of its exceptionally well organized monitoring and evaluation system, PRIME is able to document results in nearly all 85 activities in 26 countries.

- In the past four years, PRIME has trained and supported an estimated 115,000 health care providers and trainers and has monitored the outcomes of training in terms of actual performance.

    - In Kenya, 81 percent of 1,600 PAC clients were counseled for FP and half of those counseled left with an FP method.

    - In Rwanda, 85 percent of 1,167 pregnant women that were counseled accepted an HIV test.

    - In India, 90 percent of 6,948 traditional birth attendants (TBAs) were found to be performing to standard.

    - In Ghana, self-directed learning and monthly meetings increased midwives' performance in client–provider interaction from 54 to 77 percent.

    - In Benin, knowledge and performance scores in the areas of sexually transmitted infections (STI), safe motherhood, and infection prevention improved significantly.

- Provider performance in FP in Paraguay increased from 32 to 73 percent in less than a year.

Numerous other findings are already available and others will be forthcoming during the next project year.

- PRIME worked in more than 12 countries to develop national policies, protocols, and standards leading to performance expectations. There are indications of improved performance in supervision in India, Senegal, Kenya, Ghana, Armenia, and Rwanda, among others.

- Significant progress towards sustainability in training capacity has been made: national standards and procedures (Bangladesh, Mali, Rwanda); large-scale decentralized training (El Salvador, Tanzania, Bangladesh); training curricula (Paraguay, Uzbekistan, Ghana); quality training and practicum sites (India, El Salvador); and fostering linkages (East, Central and Southern African College of Nursing [ECSACON], Ethiopia postpartum hemorrhaging, Armenia, Tanzania zonal training center).

- PRIME has improved management systems in support of the primary provider, including identifying performance gaps and associated factors (28 performance needs assessments); improving infrastructure and supplies (Armenia, Honduras, El Salvador); supportive supervision and information systems (Kenya, Ghana Community-based Health Planning and Services [CHPS], Bangladesh); and cost-containment and cost-sharing approaches (Ghana, Honduras).

- PRIME has improved policies and guidelines to increase quality and accessibility through national RH policies (Paraguay, Armenia, Rwanda); national protocols to ensure evidence-based best practices (Benin, Bangladesh, Tanzania, Uzbekistan); and inserting new technical content into guidelines and protocols (STI/HIV, gender-based violence, female genital cutting, active management of the third stage of labor).

- PRIME has increased client satisfaction and the quality, access, and use of FP/RH services through incorporating consumer perspectives (Dominican Republic Asociación Dominicana de Planificación Familiar [ADOPLAFAM]) and fostering consumer–provider partnerships (Uganda and El Salvador adolescents, Rwanda Partenariat pour l'amelioration de la Qualité [PAQ] and mutuelles).

- Acting on USAID/Washington's suggestion, INTRAH/University of North Carolina (UNC) took what appears to be effective action to remove several severe administrative and fiscal constraints associated with its ties to the UNC system. The new entity, IntraHealth International, emerged on July 1, 2003, as a private, nonprofit institution able to manage its own personnel, contracting, funds receipt, accounting, reporting, and other administrative functions.

- PRIME II has assembled an impressive portfolio of field projects that have been strategically selected primarily for their potential impact and scalability. Due to numerous factors largely beyond PRIME's control, many of these will not have reached their full potential by the scheduled project end date (September 2004). It is incumbent upon PRIME and USAID to seek ways to ensure that investments to date will not be lost, and that some way will be found to continue support to key programs having significant potential for real impact.

COMPONENTS OF PRIME II TO BE PRESERVED FOR THE FUTURE

For the remainder of PRIME II as well as for the next three to five years, USAID and IntraHealth need to consider ways to safeguard several important components of PRIME II. While there are many positive aspects of PRIME's work, there are six that are seen as most important to preserve and to continue:

- focus on the primary provider;
- key project activities that have potential for major impact, either in the countries in which they are being implemented or for wider application across countries and regions;
- performance improvement/performance needs assessment;
- monitoring and evaluation;
- blended/self-paced learning approaches; and
- the PRIME II partnership model.

No basic changes should be made to the present project design as it is well conceived and has served its objective well.

I. INTRODUCTION AND BACKGROUND

INTRODUCTION

The purpose of this evaluation was to assess the performance of PRIME II and to provide guidance to the U. S. Agency for international Development (USAID) regarding the design of future projects.

Through the fourth year of the five-year project, PRIME II was implemented by INTRAH/University of North Carolina under a cooperative agreement. Beginning in July 2003 and for the final year of the cooperative agreement, a new private corporation (IntraHealth International, Inc.) was established to complete the project. The final evaluation was undertaken with approximately one year remaining in the cooperative agreement.

PRIME II contributes specifically to the strategic objective of the Training Results Package of the Bureau for Global Health, Office of Population and Reproductive Health, "Improved provider performance and sustainable, national systems for training and education in family planning and reproductive health."

PRIME II's Intermediate Results (IRs) include

- IR 1: Strengthened preservice education, inservice training, and continuing education systems
- IR 2: Improved management support systems for training
- IR 3: Improved policy environment for training
- IR 4: Better informed and empowered clients and communities

The overall goal of the cooperative agreement is to improve family planning and other reproductive health care services that primary-level service providers offer their clients. The clear focus is on improving provider performance, not just improving provider skills. At the outset of each activity, PRIME II strives to identify key factors inhibiting good performance among primary providers and to gain host country support as well as that of other organizations, as needed, to address identified performance constraints.

PRIME II divides its portfolio into four technical leadership areas:

- responsive training and learning,
- performance improvement,
- postabortion care (PAC), and
- HIV/AIDS and family planning integration.

Consumer-driven quality was one of the four technical leadership areas until July 1, 2003. The PRIME II partners made a strategic decision to move consumer-driven quality

activities into performance improvement and created a new technical leadership area, HIV/AIDS and family planning integration.

In September 2003, an evaluation team consisting of four persons was assembled by the Population Technical Assistance Project (POPTECH) to conduct the evaluation (appendix A contains the complete scope of work). All team members are senior professionals whose skills and experience include preservice and inservice training, clinical practice, management, policy and strategic planning, information technology, measurement and evaluation, and intimate knowledge of and experience with USAID organization and operations in the United States and abroad.

The team visited four countries—Ghana (Africa), Bangladesh (Asia), Armenia (Eastern Europe), and Paraguay (Latin America)—and solicited feedback from all countries in which PRIME II has worked. (See appendix B for a complete listing of the primary contacts for the evaluation, appendix C for Mission responses, and appendix D for country summaries.)

A self-assessment produced by PRIME II (appendix E) and numerous other documents were reviewed (References is the final appendix). Visits were made to USAID/Washington and to PRIME II offices in Chapel Hill, North Carolina, and telephone interviews were conducted.

BACKGROUND

PRIME II is implemented by IntraHealth International, Inc., under a five-year cooperative agreement. The first PRIME project, PRIME I, was implemented under a five-year contract. The agreement included a one-year base period and a four-year option period.

The base period was effective beginning September 30, 1999, and was authorized at a funding level of $15,228,411. The option period was effective October 1, 2000, and ends September 30, 2004, at a funding level of $88,167,768. Funding for PRIME II through fiscal year (FY) 2003 includes the following:

Core	$30,542,000	
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PRIME II is unique among USAID's service delivery projects, despite the similarity of their goals. EngenderHealth and JHPIEGO are cooperating agencies that have somewhat similar missions. However, EngenderHealth focuses its work on clinic-based, reproductive health (RH) service delivery, with special attention to family planning (FP), especially long-term methods. While organized around a clinically focused niche, the cooperative agreement permits the flexibility to address related services (such as PAC and sexually transmitted infection [STI]/HIV prevention) through such proven approaches as quality improvement and male involvement. The mission of JHPIEGO's project, Training in Reproductive Health III, is to train medical and other health care professionals via preservice and inservice interventions.

By contrast, PRIME II's focus is on improving the actual performance of the primary providers, that is, nurses, nurse-midwives, obstetrician/gynecologists, or other care providers. While PRIME II recognizes that training is a needed and useful intervention, it also emphasizes nontraining interventions and their important relationship to performance.

Since 2000, PRIME II has carried out a program to strengthen primary-level FP and RH service delivery in at least 26 countries, involving 85 individual projects (see appendix F).

With USAID support, PRIME II has developed its capacity and reputation as an international leader in the field of training, performance improvement, and PAC, including co-chairing both interagency working groups on performance improvement and PAC.

Under PRIME II, techniques for realistic performance monitoring and evaluation, begun during PRIME I, were further developed and refined. This has helped establish PRIME II as a leader in the monitoring and evaluation community, demonstrating the efficacy and utility of its methodologies.

PRIME II is a very successful consortium model that draws on the collective experience of its partners: Abt Associates, EngenderHealth, Program for Appropriate Technology in Health (PATH), and the Training Resources Group, Inc. (TRG). Save the Children and the American College of Nurse-Midwives (ACNM) serve as supporting institutions to the consortium. PRIME II has regional offices in Senegal, Kenya, Thailand, and the Dominican Republic. The Europe/Eurasia and the Middle East/North Africa regions are managed from Chapel Hill.

SCOPE OF WORK

The team was asked to assess PRIME II's performance under the cooperative agreement, to identify lessons learned, and to provide recommendations for future procurements.

ORGANIZATION OF THE REPORT

To assist in organizing its enquiry, the team was presented with a detailed question matrix by USAID/Washington as part of the scope of work. This matrix was organized around the relevant IRs (1 through 4) as well as questions pertaining to project management and future directions. The matrix served as the outline for PRIME II's self-assessment and underlies the format of this report.

Team recommendations are given in each section where appropriate and are grouped together as appendix G.

II. STRENGTHENED PRESERVICE EDUCATION, INSERVICE TRAINING, AND CONTINUING EDUCATION SYSTEMS (IR 1)

STRENGTHENING EDUCATION AND TRAINING SYSTEMS

PRIME has been engaged in many countries in activities that are focused on the development of curricula, the promotion of academic learning, the development of advanced technical skills, the reinforcement of previously acquired knowledge and clinical competencies, and the promotion of life-long learning. PRIME reports preservice training activities in 6 countries and inservice training/continuing education systems in 21 countries (see appendix E).

The majority of PRIME's work has been centered on inservice training. However, linkages with other agencies within specific countries that are also working in the field of education (specifically in preservice and continuing education) have extended PRIME's influence and impact (e.g., in Armenia, India, and Ethiopia).

Although PRIME has had a lesser degree of involvement in preservice education, in those instances when PRIME has had the opportunity to influence the preservice curriculum, these efforts have served to enhance the skills of the provider cadre upon entry into practice. This in turn lessens the need for immediate focus on skills enhancement. There are also numerous examples derived from PRIME's inservice training experiences that demonstrate the value of extending influence into preservice training. The majority of these examples would include the work that has been necessary to bring clinical training sites up to acceptable standards before clinical training interventions. For example, the team observed in Paraguay that providers at service delivery sites had to be educated in such critical concepts as infection control that might have been expected to be a competency acquired during basic (preservice) education.

Inservice training has been accomplished by applying a variety of strategies and techniques to improve the skills and knowledge of providers. One of the main training approaches includes traditional classroom-based, trainer-led training. This approach has made good use of state-of-the-art performance-based training, using participatory methods, anatomical models for practicing clinical skills, and other skills practice sessions for such areas as counseling and supervision. PRIME II saw the need to advance beyond this traditional classroom approach and to use a variety of methods or a blended learning approach.

Certain fundamental elements characterize PRIME's education-focused activities in the majority of specific applications.

- Training activities are evolved from a performance needs assessment so that interventions can be targeted to specific needs of the learner(s).

- Training strategies are linked to the country context (e.g., they are based on the leading health problems documented in country-specific health surveys; they reflect existing government policies, such as reproductive health standards and guidelines).

- Training materials are developed with the advice and consent of country-based practitioners, using such strategies as advisory counsels and key informants to ensure the cultural and linguistic acceptability of materials.

- Training interventions are linked to nontraining environmental factors that influence provider performance, such as the availability of supplies and equipment, and strategies for supportive supervision (performance expectations, feedback, and motivation) in the posttraining timeframe.

- Where feasible, PRIME engages with professional associations to ensure the sustainability of educational activities and interventions.

PRIME has developed training interventions at both the micro and macro levels. Examples can be cited for PRIME's local to national focus of activities (and scope of influence) in almost every country in which it is working. In fact, PRIME has trained approximately 115,000 providers and trainers. One example is the country of Ghana, where the team was able to witness this impact. PRIME assisted The Ghana Registered Midwives Association (GRMA) in developing a single module focused on HIV/AIDS as an addendum to a self-directed learning project that had been essentially completed at the end of PRIME I. PRIME also assisted the Ministry of Health (MOH) in Ghana to develop inservice training and materials for community-level providers who would work in countrywide, decentralized, health systems (Ghana Community-based Health Planning and Services [CHPS]).

There are numerous examples (Armenia and Bangladesh) where, for various reasons, PRIME interventions have not had enough time to achieve maximum impact. In other countries (Paraguay and Ghana), a key weakness of PRIME II activities identified was that the transfer of training capacity to local primary service providers and institutions remains a work in progress. Although PRIME has contributed strongly to the capacity of primary service providers and institutions to provide training, it is unclear whether these institutions will be able to sustain this training without continuing outside support. (Field visits in both Ghana and Paraguay confirm this perspective.) USAID recognizes that the transfer of training skills to local institutions is lacking and appears to be interested in continuing to support activities after PRIME II ends in order to address this weakness. In Ghana, a representative of the national Reproductive and Child Health Unit stated that although PRIME has done a good job of training the regional training teams, the government will continue to need support for these regional training activities. He was specifically referring to material support and indicated that if PRIME II was unable to provide this, other international donors would be asked, but the preference is to continue working with PRIME II. Regional training staff members indicated that while material support was important, they were also concerned about the continuing need for technical updates and continued outside support that made it a priority for the system to focus on safe motherhood and RH issues. Similarly, the community health officer training program is concerned about monitoring and refresher training for the supervisors who will be monitoring the community health officers as their numbers expand to the government's projected target of 5,000.

Lessons Learned

- There is a substantial benefit to be gained by fostering linkages among the preservice, inservice, and continuing education sectors within countries (responsibilities often reside in different government offices) and with other cooperating agencies (CAs) working in-country on various related projects. These working relationships enable project participants to establish clear scopes of work, boundaries, and work calendars, thereby reducing redundancy of effort and competing/overlapping time lines, promoting the philosophy of integrated learning, and fostering a seamless provider education conduit.

- Training strategies should be designed to meet identified needs for upgrading technical skills and knowledge and to have low cost requirements in terms of resources and staff time.

- PRIME interventions, irrespective of how well designed and implemented, need sufficient time to achieve their impact potential.

Recommendations

- PRIME should continue its strong efforts to promote the development of systems that can be left in place to support and sustain training efforts implemented during the PRIME II project.

- PRIME needs to continue working on training strategies that not only meet the needs to upgrade technical skills and knowledge but that also have low cost requirements in terms of resources and staff time in order to further sustainability.

- USAID/Washington should consider ways to ensure that USAID intermediaries, such as PRIME, have sufficient time in-country to maximize their potential impact.

PERFORMANCE NEEDS ASSESSMENTS

According to project documents, as of August 2003, PRIME has conducted 28 performance needs assessments in 18 countries as well as numerous other performance-related assessments and anticipates conducting additional assessments before the project ends in September 2004. The advantage of the performance needs assessment process is that it involves a broad range of stakeholders from CAs, nongovernmental organizations (NGOs), other donors to clinic/hospital staffs, clients, and community groups.

The time needed to complete a performance needs assessment ranges from a few days to several months. The timeframe is dependent upon multiple factors, including the number of performance factors being addressed, resources available, the number of stakeholders, and the amount of data collected. The assumption cannot be made that every country would be willing to invest in such a process, particularly if it was anticipated to be lengthy.

An example of a lengthy performance needs assessment process is that which occurred with PRIME's support of the Ghana Health Services' (GHS) safe motherhood project in three northern provinces. When asked to conduct training for primary providers, PRIME II recognized that there were probably numerous factors affecting performance, and requested permission to conduct performance needs assessments in these regions. Although the actual performance needs assessment took 4 months, the events surrounding acceptance of this first exercise and the wide discussion that ensued from its results extended over several additional months. The entire process took over a year to complete but most GHS staff believe it was useful. GHS staff interviewed by the evaluation team indicated that clarification of job expectations and having clear job descriptions helped clear up a number of performance problems and provided guidance for training. These individuals stated that the training for safe motherhood interventions would not have been nearly as effective if they had not had the support from stakeholders and if they had not received the required equipment and supplies that were identified through the performance needs assessment as critically necessary for carrying out the safe motherhood tasks. The hospital staff indicated the advantage of having the performance needs assessment process involve regional administrators and managers. Before the performance needs assessment, the hospital administration had blocked training efforts by not allowing staff time to conduct training or by not providing logistical support for the training and services. Now, the administration supports and facilitates all regional safe motherhood training that needs to be conducted by regional training teams. The Reproductive and Child Health Unit of the GHS in Accra has found performance needs assessments so useful that it has asked PRIME for help conducting them in the southern and western regions.

Lessons Learned

PRIME continues to experiment with alternative methods for conducting performance needs assessments most efficiently. Key lessons learned from the numerous performance needs assessments already conducted under PRIME II include the following:

- In most instances, training is not enough to bring about desired provider performance changes and to improve service quality in a given situation. When asked to improve performance issues through training, PRIME II usually asks to conduct a performance needs assessment in order to address other factors that may be affecting performance. For example, PRIME has identified and/or implemented activities addressing clear performance expectations in 40 projects and addressing the physical environment in 27 projects (see appendix H for details).

- It is critically important to obtain and maintain stakeholder commitment throughout the performance needs assessment process to ensure that those in decision-making positions will support the project. PRIME II has found that involving stakeholders increases transparency, helps partners and stakeholders own the process, makes it easier to recognize performance problems, and increases learning and sustainability on the part of local counterparts. The performance needs assessment process is associated with great variation and unpredictability and the time required to obtain stakeholder acceptance can be substantial.

- Reducing the number of desired interventions and reaching agreement on the best interventions to close the performance gaps remains a challenge. This is especially difficult when there are a large number of stakeholders who tend to want to address every problem rather than to focus on a limited number of causes of these problems.

- On those occasions where a performance needs assessment identifies gaps in areas not mandated by the PRIME cooperative agreement, partnerships have been created to ensure that such areas are successfully addressed (e.g., working with the United Nations Population Fund [UNFPA] to address contraceptive logistics).

Recommendation

- PRIME should develop a streamlined marketing tool outlining the steps and successes of the performance needs assessment process that can be shown to ministries of health in other countries requesting training.

LEARNING APPROACHES DEVELOPED, TESTED, AND USED FOR PRIMARY AND NONTRADITIONAL PROVIDERS

PRIME II has improved primary provider performance by developing and implementing blended learning approaches designed for low resource settings, where appropriate. Blending refers to the combination of two or more training delivery methods to transfer learning based on objectives, resources, and cost as well as the learner's motivation, familiarity with the media, and degree of independence. PRIME II found that blended learning approaches for RH training in low resource settings led to acceptable retention of knowledge and skills, has acceptable costs, and seems to be less disruptive than classroom training. As shown by PRIME evaluations, self-directed learning and other alternative learning approaches have resulted in 33–80 percent improvement in provider knowledge or performance in settings as varied as Ghana, Benin, and the Dominican Republic.

PRIME strives to establish decentralized learning environments, allowing training to be delivered where learners live and work. Examples include distance learning, structured on-the-job training, and structured independent self-study or the self-paced learning approaches that are being used in Ghana and Armenia. Other examples of blended approaches include community-based, small-group, peer-facilitated learning in the Dominican Republic; clinic-based, small-group learning combined with internships in Bangladesh; classroom-based, expert-led learning in El Salvador, India, Paraguay, Mali, Rwanda, Kenya, and Uganda; interactive video simulation in Kenya; and paired learning with facilitated clinical practice in Ghana and Armenia.

The team had the opportunity to interview staff that had participated in the self-paced learning approaches used in the Upper West and northern regions of Ghana. This self-paced approach was being compared with the traditional training approach, which required 3 weeks of classroom-based, instructor-led training followed by practical applications. Due to the time away from job responsibilities required to attend the

training and the limited staff at the hospitals, GHS was interested in exploring alternative training approaches that would be less disruptive. A group of 40 service providers (nurses and midwives) was selected for training in the self-paced learning approach. These individuals worked through seven modules related to safe motherhood training and met with a paired learning partner to review the material. At the end of the module, each learner underwent practical training with a facilitator. It has taken up to a year for some participants to complete all the self-paced learning modules. The Population Council is currently evaluating results from the self-paced learning approach training with that of traditional training, comparing the impact of each approach on provider performance, quality of care, and client use of FP methods. In addition, PRIME II, the MOH, and FRONTIERS/Population Council are conducting cost/results analysis of the two approaches. Preliminary results of the cost data indicate that in terms of financial costs, the self-paced learning approach was much less expensive. When opportunity costs were figured in (provider's time), the costs of the two methods were about equal. PRIME is hoping to be able to compare these cost data with the results of the performance evaluation being conducted by the Population Council to be able to determine the actual cost/benefit of the two approaches.

In Armenia, the team was able to interview numerous trainers, supervisors, and learners (nurses) who were just completing the fourth of seven self-paced learning modules. There was universal acclaim for this learning approach by all respondents. Service providers were able to relate specific examples of how their new skills had actually resulted in improved service delivery and community willingness to use their services. One enthusiastic obstetrics/gynecology supervisor reported how the training had resulted in saving the life of an expectant mother "who surely would have died otherwise."

Ongoing monitoring and subsequent revisions to the self-paced learning materials are necessary as the training activity progresses. During team visits in Ghana, it was clear that this follow-on activity had occurred. However, there was also a sense from interviews that additional revisions were needed. For example, self-paced learning relies on written text material to be read by nurses and midwives at their own pace and time, some of whom have not been in school for many years (the average age of the midwives was 40). As one participant explained, they are not a "reading culture." As the staff member of one CA stated, "there is a need for 'reader-friendly' material."

The evaluators reviewed a small sample of materials developed for midlevel health practitioners (community health officers and professional midwives in Ghana), including some of the self-paced learning modules**.** The materials reviewed were primarily printed. The quality of the reproduction was modest and the font was of average 12–point size. The materials could have been enhanced by the incorporation of figures and line drawings, both as an alternative method of presentation of text-based material and as an asset to the presentation of the materials themselves (i.e., the inclusion of more blank space on a page). This review of the materials also revealed that the reading level required for the modules was well beyond a basic reading level.

Lessons Learned

- Using appropriate combinations or blends of learning approaches can improve the transfer of learning to performance in the workplace. The critical

need is to have the correct blend and to be sure that the methods are appropriate for the learning needed.

- Blended learning approaches, such as self-paced learning, can facilitate access to learning by practitioners who are limited by time or bound by geography or employment responsibilities.

- Effective training needs to focus on improving knowledge and skills as well as the provider's workplace performance. The inherent challenge is to identify the essential training components that lead to optimum performance. PRIME and JHPIEGO jointly developed the *Transfer of Learning Guide* based on the best available evidence and combined experience as guidance for the development of performance improvement training strategies.

- Blended learning approaches can be an effective means for developing clinical as well as cognitive skills.

- It is necessary to conduct intensive monitoring and to make appropriate adjustments in order to be sure that training is appropriately meeting performance needs.

Recommendations

- PRIME should prepare materials and conduct briefings among stakeholders of the self-paced learning process to inform them of the self-paced learning approach results and to identify ways to continue the use of this learning strategy.

- PRIME should continue to develop approaches that can be used effectively in low resource settings. Approaches such as self-paced learning may be more useful for settings requiring time flexibility for staff learning but there also need to be methods for assuring that the individual learning approach is appropriate for the learners.

- PRIME is urged to explore methods for controlling timing for some of the self-paced learning methods and to develop better tools for evaluating the effects of the variety of blended learning approaches that have been developed for various country situations.

USE OF INFORMATION TECHNOLOGY

PRIME has explored a variety of training interventions as enhancements to the print-based innovations (such as self-paced learning) that characterize much of PRIME's work with adult learners. For example, in the Dominican Republic, radio drama programming was later reinforced by audiotapes of the programs by health workers to highlight the information acquired in training as well as to disseminate health messages to community residents. The use of cell phones was tested as a means to facilitate the interaction between health workers and their supervisors. Higher technological approaches are being tested currently. The innovative strategy presently in development is a program to

reinforce PAC counseling skills (Kenya) through the presentation of case studies presented on portable DVD players. The studies are interactive. Learners view several scenarios, select the most appropriate response to a review question, then receive immediate feedback about the elements that make each response more or less desirable. Initial results show that 10 PAC providers who have tested the DVD–based PAC learning program in Kenya found it to be easy to use and would recommend it as a learning tool to their colleagues. Additional results on transfer of learning will be available after the final evaluation of the project.

During field visits in Paraguay, the team learned that PRIME had used a videoconferencing training technology with trainees who were learning procedures such as intrauterine device (IUD) insertions. Learners were able to communicate with the physicians conducting the procedures through microphones while viewing the procedure from a remote location.

PRIME/Paraguay implemented another technology, introduced originally by JHPIEGO to the Latin American Center for Perinatology. The IMPAC (World Health Organization [WHO]) curriculum is used as the basis. Learners are taught to use the Internet to conduct searches (specifically the Cochrane or WHO databases) for evidence-based studies on good, neutral, and harmful medical and hospital practices. According to PRIME staff, this technology was useful because there was ready access to the Internet. However, the MOH staff in Caaguazu was not able to use it because computers were not widely available. In addition, most of the studies were in English and the MOH staff did not understand how to use the databases and analyze the studies; they generally asked PRIME staff to do it for them.

It is also important to note that information technology is a fundamental method used by PRIME to promote internal staff development and information dissemination. Country staff described the use of computer-assisted learning and web conferencing as learning resources for their personal job orientation and/or professional development. The PRIME web site serves as an invaluable educational resource for the worldwide community. Key project tools, such as *Stages, Steps, and Tools for Performance Improvement* and the *Transfer of Learning Guide,* have been disseminated via web, print, and CD–ROM formats. PRIME's monitoring and evaluation unit is testing the feasibility of using personal digital assistant devices as a field data collection tool to enhance both the accuracy and speed of data collection.

Other important uses of information technology methods and strategies include the training database developed by PRIME for use in Bangladesh and the project monitoring and evaluation system that has been uniformly applied in each country.

Lesson Learned

- As access to computers and the Internet becomes more widespread in the developing world, electronic versions of technical resources and training programs will become a viable, less costly alternative to print materials and instructor-led training. However, at the present time the utility of the technology needs to be weighed against its actual availability and accessibility.

Recommendation

- PRIME should explore alternate methods for making evidence-based best practice materials available to primary care providers. One possible strategy is for the regional offices and the Headquarters Training and Learning Unit to gather evidence-based literature regarding best practices on the most pressing problems of primary care practitioners in their regions and deliver this information in an accessible format through the country offices.

BUILDING ORGANIZATIONAL CAPACITY TO DEVELOP TRAINING CURRICULA

PRIME has adopted an instructional design approach to curriculum development. The approach incorporates the wisdom and insight gleaned from foundational inquiry into learner needs (performance needs assessment), the input of stakeholders, and an iterative approach to materials development.

PRIME has demonstrated its ability to work collaboratively with a full spectrum of health workers. The self-assessment prepared by PRIME provides the detail of a variety of reproductive health, safe motherhood, and primary health (e.g., infection control) projects conducted among the broadest spectrum of health sector workers, ranging from paramedical personnel (such as community health promoters) through physician-specialists. (Illustrative examples are cited for 11 countries.) This requires that PRIME recognize and appreciate the educational level achieved by the worker cadre and incorporate that baseline into the materials that are adapted from other PRIME–assisted curriculum development projects or from other (external) sources.

A benefit of PRIME's work in multiple countries among a broad variety of worker cadres is that lessons learned from one country can often be adapted by others, using the instructional design approach noted above. For example, a safe motherhood training package developed in Nicaragua was adapted for use in Paraguay. A facilitated supervision curriculum developed and tested by PRIME in Honduras was also adapted for the Paraguay country context. Training systems developed for the PRIME India programs, such as monitoring and follow-up systems, were used in the Bangladesh National Integrated Health and Population Program (NIPHP) and were further adapted for the Bangladesh Health and Population Sector Program (HPSP).

PRIME has also explored blended learning approaches as well as the incorporation of technology into the curriculum dissemination process, as noted in other sections of this report. In summary, these innovative/experimental approaches are noteworthy for their purpose in extending educational access and are being fully tested before wide application.

Lessons Learned

- Curriculum development is best achieved through the participatory process as the strategic involvement of stakeholders is critical to the quality and acceptability of the materials that are developed. Stakeholders include the

administrative authorities that have responsibility for assuring the congruence of training with existing (or emerging) policies and guidelines, trainers, and other content experts (preferably both preservice and inservice), supervisors, and the learners themselves. PRIME notes that the early involvement of local training organizations in the curriculum development process is key to their ownership of the training, which is critical to the transfer of learning process.

- The performance needs assessment that underpins the curriculum development process is a critical step because it leads to the development of curriculum content that is targeted to performance gaps. This leads to a streamlined and focused learning activity that builds on the existing body of knowledge and skills that the learner brings to the learning process. The performance needs assessment also identifies the nontraining interventions that are critical to the effective implementation of quality performance in the workplace.

Recommendation

- PRIME should be encouraged to maximize the involvement of individuals with technical expertise in the production of instructional materials on each curriculum development team so that the materials are easier to use in terms of the amount and type of printed matter, the use of illustrations, and similar issues concerning the format used for presentation. The materials need to be thoroughly pretested among the target audience to ensure that they are appropriate and usable.

TRAINING SITES ESTABLISHED

The self-assessment documents the work conducted by PRIME to assist country government agencies and other organizations to identify potentially appropriate clinical training sites and then either to establish or upgrade these sites in preparation for clinical training interventions. Eleven exemplary countries are named; nearly 100 multiple sites are noted in each country. (It was noted by PRIME that this list is not exhaustive.)

The following commonalities were characteristic of PRIME's training site development efforts:

- The currency and sufficiency of sites were assessed in accord with national reproductive health standards and guidelines, where these existed.

- In the instances in which current national standards were not in existence, PRIME assisted in the development or adaptation of standards, using extant materials as a baseline.

- Guidelines and checklists were used in the selection and evaluation of sites; these evaluation tools provided criterion-referenced (objective) support of the importance of materials/supplies/equipment that were considered essential in each setting. These tools were left in place for future use by others who

would assume responsibility for the sustainability of the quality of sites and settings.

- PRIME took steps to transfer capacity for the sustainability of sites/settings by training supervisors/master trainers employed both at national and regional or local levels of service to conduct ongoing needs and quality assessments.

- PRIME assisted in the logistical efforts required to properly equip settings in anticipation of training interventions as well as to promote the development of logistical supply channels (e.g., PAC training in the Caaguazu district of Paraguay, active management of the third stage of labor training in Mali, and PAC training in Kenya).

PRIME promoted the sustainability of clinical training interventions within these established sites by

- selecting and enhancing the skills of already highly qualified individuals who were motivated to serve in the role of master trainer,

- promoting the development of training management information systems for monitoring training quality and performance to standards,

- promoting communication between administrative personnel at the clinical facilities and educational personnel at preservice and inservice institutions to foster collaborative efforts to sustain the quality and ongoing availability of these sites and settings, and

- promoting the development of business and marketing skills to keep the sites financially self-sufficient.

PRIME reports that the vast majority of clinical training sites that it helped develop are continuing to function and that steady progress is noted in the transition of these sites to local management authority. The materials supply conduit is not firmly established in a number of these sites (e.g., Paraguay and Ghana); PRIME continues to receive requests for ongoing support of basic clinical equipment and commodities. This factor represents the greatest of challenges for the sustainability of clinical training sites in the post–PRIME period. PRIME has done what it could to raise the consciousness of local authorities to seek local solutions and/or alternative sources of supply. In an effort to ascertain the degree of sustainability of training institutions and training sites, PRIME has developed tools to measure institution strengthening (PRIME Technical Report No. 16). In an adapted version of this tool, PRIME was able to confirm in Bangladesh that six institutions had increased their training and management capacity from 17.3 to 32.3, according to a composite score consisting of seven dimensions of capacity (PRIME Technical Report No. 41).

PRIME has also identified the difficulties that can be encountered in ensuring sufficient client volume for appropriate clinical skills training. Certain procedures can be modeled (e.g., manual vacuum aspiration, IUD insertion, and active management of the third stage of labor procedures, such as bimanual compression of the uterus). However, training on

anatomical models needs to be augmented and supplemented by real life encounters, which, in the instance of obstetrical experiences, can neither be anticipated nor scheduled. PRIME has responded to this challenge by requiring a historic record (documented volume) of these events in the setting as one site selection criterion. This criterion has the offsetting impact of requiring that learners gather in a teaching center that may be remote from their geographic residence (perhaps even in another country, as was the case when clinical providers from El Salvador were brought to the Dominican Republic for PAC training). PRIME's experiments in blended and distance learning approaches are attempts to ameliorate this adverse impact by limiting the time that is needed in place for clinical practice.

Recommendation

- PRIME should promote the sustainability of training sites by incorporating a time line, with buy-ins from host country institutions, CAs, and/or NGOs for assuming responsibility for the follow-on activities of continued educational support and materials supply.

LINKAGES FOR PROVIDER MENTORING AMONG PROFESSIONAL SCHOOLS, ASSOCIATIONS, AND SERVICE DELIVERY SITES

PRIME has recognized the wisdom, vision, and influence of professional associations and academic institutions in support of its service delivery site development and clinical training efforts. There are many examples of PRIME's exploitation of the value of such relationships.

PRIME worked with nursing schools/institutions in Mali to enhance the skills of teachers in certain safe motherhood concepts (FP and female genital cutting). These academic institutions are now poised to revise their curriculum to introduce this topic content into the basic course of studies. Similarly, PRIME's relationships with the East, Central and Southern African College of Nursing (ECSACON), representing 15 countries, have fostered action taken by these member schools to introduce FP/RH performance standards into preservice nursing education programs. PRIME is working with the Armenian Medical University and members of the family medicine association to develop the RH component of the family medicine curriculum. It has worked with the Technical Training Unit of the Ministry of Health and Family Welfare in Bangladesh in a preservice linkage with an undergraduate medical college to influence an essential services curriculum. PRIME's work in the Dominican Republic has resulted in a memorandum of understanding between a major teaching hospital, the national obstetrician/gynecologist society, and three medical universities that will result in a major revision of the basic medical curriculum.

PRIME's investment in fostering relationships with professional associations has generated good will and the supportive involvement of these associations, which encourage the active participation of their membership in both inservice and continuing education activities. The following are a few of many examples:

- The Ghana Registered Midwives Association (GRMA) has promoted the self-directed learning activity (initiated under PRIME I), expanded it during phase

II of the implementation for another group of 52 learners, and expanded the adolescent RH curricula to include a module on HIV/AIDS.

- The National Nurses Council of Kenya has had a key role in establishing support for PAC services among nurses and midwives.

- Clinical practice standards for practitioners engaged in safe motherhood activities have been jointly promulgated by obstetricians, midwives, and the MOH in Ethiopia.

IMPROVEMENT OF MANAGEMENT SUPPORT SYSTEMS

PRIME recognizes that providers that benefit from preservice and inservice training also need managerial and supervisory support while on the job to sustain performance. PRIME has found it useful to provide training for supervisors in the area of supportive supervision, which teaches them to be supportive and have a coaching role with the staff they are training. In India, PRIME helped to train 1,000 lady health visitors in supportive supervision; results showed that these supervisory practices assisted 88 percent of 9,500 auxiliary nurse-midwives to maintain performance levels. Similar results are being reported in Armenia, Benin, Ghana, Honduras, Kyrgyzstan, Rwanda, and Senegal. The team had an opportunity to discuss the supervision-related activities in Ghana and Paraguay. Capacity was built in Ghana through the development of an on-the-job training guide, which was used as a guide for trainers who work with community health officers. Future plans include working with EngenderHealth to provide additional facilitative/ supportive supervision training. In Paraguay, PRIME has used the facilitative/supportive supervision methodology that was developed in Honduras to train 35 regional service delivery supervisors who in turn developed six regional action plans to improve services management at the local level.

In many areas, it is difficult for government health staff to reach outlying areas and provide supervision on a regular basis. In response to such a situation in Honduras, PRIME decided to implement a peer group approach to supervision to provide additional support for the providers. PRIME helped train peers to support one another with feedback, coaching, and mentoring skills. PRIME also has used peer support strategies for nurse-midwives providing FP and PAC services in Kenya and as an adjunct to regular supervision for community health promoters in the Dominican Republic.

Lessons Learned

- Many traditionally trained government workers have been accustomed to receiving little or no supervision or supervision that uncovers problems but does not address solutions to the problems. Both hospital staff and supervisors found a system of supportive supervision to be helpful and empowering in their work.

- One of the biggest challenges in working with MOH supervision systems is the lack of logistical support and staff time that will allow even motivated supervisors to work on supervision on a regular and timely basis. PRIME's

work in developing alternate supervision strategies, such as peer group supervision, is important for this reason.

Recommendation

- PRIME should continue to develop alternative posttraining support strategies, such as peer group supervision.

MONITORING AND EVALUATION OF PROVIDER PERFORMANCE

The results framework that has been adopted by PRIME as the conceptual model for its monitoring and evaluation program is consonant with the results-oriented strategy posed by USAID/Washington in the *Training Results Package for Improved Provider Performance and National Training Capacity*. The overarching objective of the USAID/PRIME II initiative is "to improve provider performance and sustainable national systems for training and education in FP/RH." Four Intermediate Results, also defined by USAID, form the program domains under which PRIME II's body of work is organized. At the operational level, the performance monitoring plan is driven by measurable outcomes (key indicators). Ten key indicators are used to monitor progress toward achievement of these outcomes.

The performance monitoring plan was conceptualized in the earliest years of the PRIME II project. PRIME II's monitoring and evaluation efforts are implemented in-country by monitoring and evaluation specialists or consultants who are directly trained and supervised at the country level and indirectly supervised and supported by regional evaluation managers from Chapel Hill.

The conceptual model and its component elements are clearly delineated in the PRIME II monitoring and evaluation materials that accompany the PRIME II year-to-year work plans and are clearly reflected in the specific country work plans. The use of a consistent set of key indicators enables PRIME to analyze, interpret, and report the results of its interventions in a congruent manner across all countries in which PRIME works.

Valid and reliable data are central to any monitoring and evaluation plan. Validity of data is conceptually linked to the appropriateness of the definitions of the measures and the congruence between the concept to be measured and the ability of the measurement tool to capture that essence. Reliability is based on the accuracy with which the concept is measured (reproducibility of data), which is a function of both the measurement instrument itself and the method and manner in which the data are gathered.

The inherent validity and reliability of the measurement of provider performance was questioned by the PRIME II monitoring and evaluation director in the earliest years of the PRIME II project. A meeting of 18 monitoring and evaluation specialists from 10 organizations working in FP/RH training and service delivery was convened by PRIME II. The desired outcome of that meeting was to arrive at a consensus on the definition of provider performance in FP/RH service delivery and to define indicators for measuring provider performance. Results of the meeting are presented in the technical bulletin, "Measuring Provider Performance: Challenges and Definitions," published by PRIME II/INTRAH and MEASURE.

Consequently, PRIME II's approach to the measurement of the first of the 10 key indicators (number and percentage of providers performing to standard) is based on a thorough understanding of the construct of provider performance. This understanding indicates that it is imperative to move beyond the measurement of the acquisition of knowledge and skills to also measure the effective/appropriate transfer of those skills through measuring on-the-job performance according to agreed-upon standards of best practice. The outcomes of these efforts are clearly reflected in the reports and documents that promulgate the results of PRIME II activities.

The commitment to valid measurement of provider performance requires that PRIME reexamine the issue at the onset of every provider-training venture. Application of the performance improvement process leads to identification of gaps in knowledge and/or skills that should be the primary focus of the training curriculum developed (or adapted) for the particular training event and cadre of provider. The acquisition of skills is affirmed through observation of skills performance (using models or in actual practice). Clinical observation checklists are used to document performance and are useful as self-assessment tools. Pre/post intervention data are used to demonstrate the effectiveness of training, health system impacts (service statistics), and the outcomes of care (including perceptions of quality) as well as to provide feedback for use in the ongoing performance improvement cycle.

PRIME also acknowledges that skilled provider performance is translated into measurable outcomes that reflect consumer use of services and satisfaction with the care that is received. Accordingly, baseline measurements taken before virtually every planned intervention focus equally on provider, facility, and consumer-oriented measures of quality provider performance.

PRIME advocates with country stakeholders for the adoption and use of externally developed, criterion-referenced, performance standards (e.g., WHO standards for infection prevention). When agreement was reached, these standards would be identified as desired performance (an essential element in the performance improvement process). It is the case, however, that during the process of negotiation with country counterparts, certain items within these externally developed documents might be amended, either by omission or by augmentation. This process of coming to consensus with country stakeholders (i.e., agreed-upon standards) resulted in variations in the standards adopted for and instruments developed for assessment of provider performance among the countries in which PRIME implemented similar projects. Additionally, in several instances, PRIME II used more global and/or normative cut-off points (e.g., an arbitrary percentage score) for the determination of what meets the standards rather than an outcomes-linked, criterion-referenced standard of performance. Therefore, the computation of the performance to standard may have a different meaning across country projects and has the drawback that PRIME is limited in its ability to compute comparative statistics, such as average performance, across similar project activities in various countries.

PRIME's monitoring and evaluation efforts are truly exceptional among USAID CAs and contractors in both the quality of design and implementation. PRIME has demonstrated

the feasibility and practicality of routinely measuring and reporting meaningful results in a useful timeframe for program decision-making.

Lessons Learned

The development of criterion-referenced measurement tools presents certain challenges and difficulties.

- Tools must be relevant to the competencies expected of the worker. These competencies may differ from county to country, depending on the reproductive health standards, guidelines, and scope of activities that are authorized for cadres of providers who may share the same job title (e.g., midwife). PRIME acknowledges its awareness of this challenge and has documented its efforts to verify the appropriateness and relevance of existing instruments to the specific settings in which they are used.

- Standards of competency should be objectively determined and linked to client outcomes. PRIME has adapted criterion-linked performance standards to national contexts, where required. Although this may represent a challenge for cross-comparisons among countries and cadres using reported composite scores, sufficient common items should exist to allow for basic comparison and summative evaluation from a subset of data.

- Outcome expectations need to be stated in measurable terms, and global assessments (e.g., maintains client confidentiality) need to be augmented with statements of specific behaviors that demonstrate the application of the principle. PRIME acknowledges that the use of measurement instruments that are too broadly worded has on occasion resulted in a loss of precision in measurement.

- Consumer satisfaction is always a difficult construct to measure as respondents are often compelled to offer the socially desirable response. These cultural biases confound attempts to measure this important indicator of quality services. PRIME is aware of this limitation; its response to this challenge has been to treat satisfaction measures as supplementary to the main indicators and often as qualitative information to add context to technical reports.

Recommendations

- PRIME should continue in its lead role in the monitoring and evaluation community in the ongoing effort to determine criterion-referenced standards of provider performance as well as methods to measure these outcomes.

- PRIME should maximize opportunities to disseminate the results of its strategies and outcomes. Presentations at global health forums and publication in the peer-reviewed literature are encouraged.

- USAID/Washington should find ways to ensure that PRIME's unique and valuable contribution to monitoring and evaluation is not lost after the present cooperative agreement terminates.

III. IMPROVED MANAGEMENT SUPPORT SYSTEMS (IR 2)

USE OF PERFORMANCE IMPROVEMENT IN STRENGTHENING MANAGEMENT SYSTEMS

PRIME II has used performance improvement methods to strengthen management support of health systems by focusing on what primary providers need in order to perform to standard and then analyzing the organization to determine the most appropriate source from which to receive this support. PRIME has outlined the following steps for this process:

- understand the overall RH system goals for the country, region, and district in which the providers work;
- align provider goals and desired performance with the overall health system goals and describe desired provider performance;
- assess actual performance;
- determine the root causes of gaps between desired and actual performance (if a new performance, determine the performance factors required of providers); and
- examine the health care system to determine the best sources and opportunities for management support.

When the types of management support needed have been identified, PRIME reviews the existing support systems. After comparing the needs with available systems, PRIME is able to determine the kind of management support it can provide.

An example of how performance improvement has been used to address health service management is that of the safe motherhood provider system in Ghana. Provider goals were compared with the overall goals of the safe motherhood system, in accord with the steps of the performance improvement process. Findings indicated that providers had received training and had good safe motherhood skills. However, the providers still needed supervisory feedback, coaching, and encouragement when using these new skills. PRIME then looked at the supervision system. Findings indicated that the system, as it existed, did not provide for ongoing support to supervisors and regional resource team members so that they could work effectively on their own to provide supervision and support to frontline practitioners. The supervisors and the regional resource team were left without sources of higher order supervision of their own skills after they completed basic supervision training. Once PRIME discovered this gap, it arranged for the regional resource teams to be integrated with the regional RH system and to be supervised by the regional directors, who set performance goals, provided feedback, and encouraged the regional resource teams in their supervision duties. As a result of this support, the regional resource teams significantly increased supervisory visits to safe motherhood providers (from 40 to 67 percent).

The safe motherhood providers reported to the evaluation team that one of the most important types of support they had received occurred as a result of the performance needs assessment that had highlighted the lack of administrative and logistical support for training and supervision. When the need for assistance with travel and logistics was made clear to the administrators through the public performance needs assessment process, the administrators became much more helpful in removing bureaucratic obstacles and facilitating the work of the regional resource teams and supervisors.

PERFORMANCE IMPROVEMENT CHALLENGES AND LESSONS LEARNED

The key lesson that PRIME has learned about management support systems is that even though its work may be focused at the primary provider level, management improvements usually entail intervening at several organizational levels. Identification of problems at one level often creates a need to address them at several levels in the organization. As noted in the Ghana example, often the primary provider supervisors are also lacking support from their superiors. Thus, one of the biggest challenges with limited resources is to determine the extent to which PRIME can address these multilevel organizational management issues. If PRIME is not positioned to address the entire problem, then the task often is to identify the entity that may have this capability. One solution has occurred in Armenia where PRIME has teamed up with Management Sciences for Health's Management and Leadership project to simultaneously address primary provider supervision systems (PRIME) and the human resource system in the MOH (Management and Leadership). It is anticipated that this more thorough management intervention will result in a sustainable human resources system that also meets provider needs.

Recommendation

- PRIME should consider compiling a sourcebook detailing the effective strategies that it has used to enhance provider performance. Drawing on PRIME's experience, the document should outline key steps to follow and alternative steps that can be taken depending on the circumstances and results at various stages in the process. It should include examples as well as lists of CAs and other organizations that can assist in addressing management support needs.

IV. IMPROVED POLICY ENVIRONMENT (IR 3)

IMPROVED NATIONAL STANDARDS, GUIDELINES, NORMS, AND PROTOCOLS FOR SERVICE DELIVERY AND PRESERVICE EDUCATION

PRIME reports its involvement in the development of these documents at three levels:

- updating national protocols (eight countries),
- integrating new training protocols and job descriptions/performance expectations based on updated national RH protocols (five countries), and
- developing training protocols and job descriptions/performance expectations based on updated national RH protocols (five countries).

PRIME's assistance in the development of national protocols has had seminal influence in some countries (Bangladesh, Nicaragua, Rwanda). In many other countries, PRIME has assisted in the revision and/or augmentation of existing documents to reflect contemporary standards and practices (e.g., new information concerning STIs, HIV/AIDS, gender-based violence, female genital cutting, and the active management of the third stage of labor). In each country in which it worked, PRIME also took appropriate initiative to foster or facilitate the dissemination of these guideline documents. USAID/Armenia cited PRIME's work in developing national standards for infection prevention as a major accomplishment.

PRIME's work in this policy area is also reflected by the actions it took to use these documents to guide the development of provider performance improvement initiatives. Making this link between policy and practice visible to learners engaged in preservice or inservice training serves the purpose of affirming the critical value of such documents. PRIME acknowledges that the existence of guideline documents made it much easier to develop the curriculum for specific training interventions.

Nevertheless, there is at least some skepticism about the effectiveness of the dissemination of these documents or their integration into the consciousness of the workforce. One USAID administrator (Paraguay) noted her perception that the documents were used in those areas in which PRIME worked, but that they were far less visible in other sectors. Similarly, the MOH in Armenia was not satisfied with the outcomes of PRIME's efforts to update the National Reproductive Health Policy and Standards framework, although the separation between expectations and outcomes has not been precisely identified.

IMPROVED POLICY DEVELOPMENT, DISSEMINATION, AND IMPLEMENTATION

PRIME has recognized that a clear FP/RH service policy is critical for both training and performance improvement. As a result, in selected countries, PRIME has worked with the leadership in the MOHs to assist in the development of national RH policies. In this process, PRIME uses performance improvement strategies to assure that changes in the

policy environment will enhance service delivery and accessibility. Once the policy has been updated and revised in a manner that empowers clients and providers and maximizes quality, PRIME implements interventions that are consistent with the findings of the performance needs assessments.

Case Examples

In Armenia, PRIME helped the MOH organize a policy document that defined roles of RH providers and established priorities for elements within all areas of RH. Although the document has not been officially adopted at this point, it has helped to guide PRIME's work there with primary providers, including the expansion of the roles of nurses and midwives. PRIME also organized a national policy forum in which stakeholders and experts met to define RH and child health services gaps and to make recommendations based on WHO guidelines. The results of the forum led to PRIME's participation in the development of national RH legislation. The MOH used the national forum report to draft the national health policy for 2004–2009.

PRIME assisted the MOH in Rwanda in drafting the first national reproductive health policy since the 1994 war. The policy process was initiated through a roundtable conference that was followed by the MOH and its RH partners collaboratively drafting a policy that was then presented to the MOH in 2002. The policy was eventually signed in July 2003 and will be disseminated nationally.

PRIME has worked with the MOH in Ghana to identify the service package to be delivered by a new community-based cadre, the community health officer, as part of the new Community-based Health Planning and Services (CHPS) initiative. After defining the primary care services that the community health officers will provide, PRIME developed an orientation curriculum for them. PRIME has collaborated with JHPIEGO, the Johns Hopkins University/Population Communication Services project, the Population Council, and EngenderHealth to implement and expand the community health officer program in 28 districts. PRIME has also assisted the MOH in assessing 20 districts for readiness to participate in the CHPS program. In addition, PRIME has conducted a cost analysis of a CHPS district that will assist the MOH in calculating the costs of expanding the impact of CHPS in the future.

PRIME conducted an evaluation of the MOH (Paraguay) 1997–2001 national RH policy. The process involved extensive stakeholder interviews as well as observations of providers in facilities and 20 focus groups. The results indicated that there had been a weakness in the area of dissemination of reproductive health information. Currently, PRIME is assisting the MOH in the design of a new RH health plan that will be used as a basis for the 2003–2008 health policy. This participatory process includes stakeholder workshops in all of the country's 17 geographic regions. The team had an opportunity to interview the PRIME consultant involved in the process who indicated that currently there was a high level of enthusiasm about the development of the new plan among stakeholders and government officials. There is concern, however, that the policy be disseminated properly once it is developed. He indicated that in the stakeholder meetings, PRIME and others were asked to commit to disseminating the final document in each of the regions. Currently, the plan is that PRIME will provide training and dissemination of

the new policy once it is in place. However, there is concern as to whether there will be enough time to complete dissemination before PRIME ends in 2004.

Recommendation

- In each country in which PRIME is currently engaged in activities in support of policy development, PRIME should take steps to ensure that this important process continues.

ASSURANCE OF INFORMED CHOICE IN FAMILY PLANNING AND REPRODUCTIVE HEALTH PROJECTS

PRIME's work in promoting the policy of informed choice is intricately linked to its activities in IR 3 (improved policy environment) and is strategically linked to its initiatives in IR 4 (better informed and empowered clients and communities). PRIME activities in several countries were oriented toward making the principle of informed choice a visible issue within reproductive health policies and guidelines. This was balanced with consumer-oriented initiatives (posters and educational materials) that reinforced and supported this value-driven perspective and were prominently displayed in health care service settings.

A component of PRIME's work in each of the 26 countries included provider training. Informed consumer choice is a value that was reflected in all of the RH and safe motherhood materials reviewed by the evaluation team. The issue is given objective visibility in forms such as curriculum content, job aids for providers and supervisors, and teaching aids for tutors and trainers.

There are several examples within country scopes of work that demonstrate PRIME's initiatives to make informed choice of contraceptive options more available and accessible. New cadres of providers were trained to provide FP counseling and services (e.g., Community Midwives in India, maternity home assistants upgraded to community-based distribution agents in Ghana). The skills of other cadres were enhanced by the addition of new competencies in FP and RH (e.g., Indigenous Systems of Medical Providers in India, pharmacy agents in Benin). PRIME also engaged in activities in many countries, often in collaboration with other CAs, to create effective and sustainable systems of supply for RH and FP commodities. Generally, PRIME training curricula include information about all FP methods available in a country as well as RH decision-making and client–provider interaction skills. The first module of PRIME's *Reproductive Health Training for Primary Providers: A Source Book,* has a section devoted to counseling clients to enable them to make informed decisions about FP/RH.

Field visits by the team generated sources of subjective confirmation that the message of informed choice had been clearly conveyed to learners engaged in PRIME clinical training initiatives. Commitment to this value was forthcoming in interviews with a broad cadre of workers. For example, PRIME collaborated with EngenderHealth in Paraguay to train MOH providers in informed choice and informed consent. PRIME later trained all 23 staff in the facilities where the project is working and developed job aids and a poster on client rights that was prominently displayed in all of the facilities visited by the evaluation team. All clients sign an informed consent form before choosing an FP

method. Numerous staff members mentioned informed consent/choice as one of the training subjects they had been taught and commented on how it helped them reevaluate their attitudes towards patients. This training greatly helped them to change their attitudes about clients and to begin to view them as the owners of the service rather than the providers. The team heard similar comments about the importance of informed choice as a regular component of FP counseling in Ghana and how it had been incorporated into both the safe motherhood training in the northern provinces as well as the community health officer training.

V. BETTER INFORMED AND EMPOWERED CLIENTS AND COMMUNITIES (IR 4)

STRATEGIES USED TO INFORM AND EMPOWER CLIENTS AND COMMUNITIES

Recognizing that when clients are informed about their health care rights and service options they are more likely to access care, PRIME II has promoted a strategy of integration of consumer perspective within its programs and included it as part of the performance improvement technical leadership area. Formerly, this strategy was in the consumer-driven quality technical leadership area. The purpose of this approach is to teach providers how to make use of consumer input to improve services. PRIME has focused on developing tools and strategies that would allow providers to better understand client's needs. The strategies are designed to transform ingrained provider beliefs about how they treat clients, make care decisions, and structure their work.

The integration of consumer perspective approach includes four steps:

- increase access to FP/RH services by better understanding consumers,
- improve quality of care by customizing and redesigning FP/RH services based on consumer perspectives,
- enhance consumer satisfaction with FP/RH services by strengthening provider–client partnerships and interaction, and
- increase the use of FP/RH services by assuring that consumers will continue to access services.

Based on these steps, the approach next defines quality services through the consumer's needs and perspectives, which include provider technical competence as assessed through consumer input into provider norms and protocols for quality services, an appropriate constellation of FP/RH services that are convenient and acceptable to clients and responsive to consumers' needs, caring and understanding of respectful client–provider interaction, and timeliness of care.

Examples of instances where these strategies have been applied include Rwanda, where PRIME used its Save the Children partnership to apply the consumer-driven quality approach by linking quality assessment with community mobilization. In two pilot sites, Save the Children staff worked with the MOH to explore community member and health worker definitions of quality, revealing that both held the same definitions of quality services. In the Dominican Republic, PRIME worked with an FP NGO using EngenderHealth's client-oriented, provider-efficient services (COPE®) methodology to collect consumer feedback about RH needs and barriers to service use. This process resulted in a number of service improvements, including increased privacy, increased types of services offered, decreased waiting time, and increased quality of interaction with the provider. The clinic director believes that these improvements led to dramatic increases in the number of clients served (from 900 to 1,900 per quarter) and in clinic

income (from 28 to 60 percent paying clients) in 2002. Community COPE strategies were also used in Nicaragua to make pharmacists sensitive to the needs of adolescents for reproductive health services. Training was provided to peer counselors through youth organizations.

Team interviews with MOH staff working with PRIME–supported training, particularly through facility-based COPE training and informed consent, revealed that there had been significant improvements in relations between providers and clients. PRIME/Paraguay conducted a midterm evaluation of the MOH health centers in its alliance project in March 2003. The evaluation showed an increase from 32 to 73 percent in provider performance improvement. The measurement was based on an index that includes counseling, informed consent, technical competence, client–provider interaction, and availability of methods.

Lesson Learned

- Originally, the integration of the consumer perspective technical leadership area was conceived as its own technical leadership area. It was later decided that it fit better as a performance improvement strategy. Part of the problem appears to be in orienting the "better informed clients and communities" from the perspective of the primary care provider. In this case, the objective is to improve the provider's perception and treatment of the client as a means for encouraging the client to use services (supply side). Although efforts are made to consult the client about service needs and suggestions, this is done from the perspective of the provider and often at the facilities. This is appropriate given that PRIME's mandate is to work with primary care providers; while community input may be sought, the focus is at the facility rather than the community level. For this reason, "better informed clients and communities" fits better with the training or performance improvement areas.

CHALLENGES FACED IN ENGAGING CLIENTS

PRIME is a provider-focused project whose objective is to assure that service providers meet consumers' preferences and needs. One of the challenges that the project has faced is the need for providers to change their attitudes towards consumers. It is important for providers to

- listen to consumers' perceptions about quality of care to understand clients' needs,
- ensure that providers make the required attitudinal changes, and
- show consumers that they have made the changes because of the concerns they expressed.

PRIME learned that these three steps were necessary for successful consumer–provider understanding. For example, PRIME discovered that pharmacists in Nicaragua changed their attitudes about offering RH services to adolescents after a workshop that focused on awareness of adolescent service needs.

PRIME's strategies to inform and empower clients and communities are from the perspective of the provider, or supply driven. As a result, some of the country programs have noted that even though they have worked to improve provider skills and attitudes, they have still not been able to increase the demand for services. In fact, many of the successful consumer-oriented projects are those where PRIME II has coordinated with other agencies that have focused on community mobilization as a complement to the provider-focused activities being conducted by PRIME II. Examples include the Rwanda project with Save the Children conducting the community mobilization activities and the Nicaragua adolescent project with pharmacists, which has PATH helping with community COPE activities. In Ghana, PRIME's clinical training of district health teams and community health officers has been nicely complemented with the work of the Johns Hopkins University/Center for Communication Programs and its Save the Children partner who are conducting community mobilization activities in the communities in which the PRIME II–trained community health officers will work. In Paraguay, PRIME II is working with two other partners to strengthen community and primary-level health care. While PRIME II works with the providers and clients at the health facility level, the other two partners work in the communities on community organization and mobilizing members to use the local services.

PRIME has also recognized that consumers do not often have much free time and that it is important to arrange meetings and services in places and at times convenient to the clients. In the Dominican Republic, participation increased after PRIME changed times and meeting places. PRIME also has learned that the orientation to consumer needs and preferences needs to come from the leadership of the health facility and larger system. Ministries of health, professional organizations, and USAID Missions all have key roles in emphasizing the importance of client satisfaction and consumer quality. MOH personnel in Paraguay and Ghana both noted that the demand for services increased significantly once the directors placed emphasis on addressing community needs and preferences. Despite the difficulty in documenting increases in client satisfaction because baseline levels tend to be high due to courtesy bias, PRIME was effectively able to demonstrate pre and postintervention increases (e.g., from 73 to 88 percent and from 84 to 95 percent) in the Dominican Republic and El Salvador, respectively.

PRIME has also found that for quality to be maintained, the bridge between providers and consumers needs to be sustained. In the Dominican Republic, Ghana, Paraguay, and many other places, community health workers and community leaders gained status in the community by working to meet community health needs. This type of nonfinancial gain makes it more likely that these activities will continue without additional external support. In an effort to stimulate sustained community activity, PRIME has developed a consumer-driven quality toolkit comprised of home visit interviews for consumers and community talk guidelines.

Lesson Learned

- The most effective way to empower and inform communities and clients is to work from both the supply side, as PRIME II does to increase provider awareness and skills in meeting community needs, and the demand side by

becoming partners with organizations that can conduct community mobilization activities and increase demand for these services.

Recommendations

- PRIME should continue to develop partnerships with local and international community development organizations in order to increase local awareness and generate demand for PRIME–supported quality services.

- In areas where PRIME II is involved in training community health workers, PRIME should explore mechanisms to assure that these workers will continue to receive new training and updates so that they can continue to feel empowered to perform their jobs.

ENSURING FP/RH CLIENTS MAKE INFORMED DECISIONS ABOUT THEIR FERTILITY

The interface between PRIME's work in promoting better informed and empowered clients and communities and its work in improving the policy environment in order to promote informed choice is noted again. Policy initiatives in which PRIME has engaged (IR 3) foster a top-down approach that promulgates the philosophy of informed choice. This message is conveyed from the highest levels of health care administration to the various cadres of FP/RH providers. The message is made visible within national standards and guidelines documents that PRIME has helped to develop, upgrade, or augment in many countries.

Similarly, PRIME engages in both preservice and inservice provider training and exerts influence to make the philosophy of informed choice highly prominent within curricula and similar training materials. Provider training in clinical skills for the provision of RH and FP services is augmented by nontraining interventions, such as systems of supportive supervision and feedback, that offer providers the opportunity to reflect on the manner and effectiveness of their approaches to counseling and services.

Client education materials further promote the message of informed choice. PRIME makes best use of materials already prepared by other CAs, such as the International Planned Parenthood Federation (IPPF), that have FP/RH information, education, and communication as a primary mission.

VI. MANAGEMENT

LEADERSHIP, MANAGEMENT, AND PARTNERSHIP

Structure of IntraHealth and the Impact on PRIME II's Mission

The PRIME II cooperative agreement was negotiated with INTRAH, located in the School of Medicine of the University of North Carolina (UNC), Chapel Hill, North Carolina. INTRAH has a long history of cooperative agreements and contracts with USAID's Office of Population and Reproductive Health, dating back about 25 years. Over the years, as the size and complexity of the program grew, INTRAH'S dependence on UNC's operating rules and regulations, formulated and regulated by the state for activities taking place in the state, became increasingly cumbersome. These rules applied to recruitment (and preferences therein), advertising, acquisition, subcontracting, and accounting. Additionally, the overhead requirements of the university system began to hamper INTRAH'S ability to be cost-competitive. In all of these areas, there are visible signs of inefficient practices that to some degree hampered the implementation of the PRIME II project.

Perhaps the most troublesome and persistent of these constraints relates to the accounting system. The team heard from several present and former senior PRIME II managers as well as USAID personnel, who expressed their frustration and dismay at being unable to obtain needed financial information in a timely fashion. One manager noted that "it was impossible for senior managers to obtain good financial information, despite repeated tries, resulting in our near inability to do budget-based forecasting." This was a common refrain from those willing to talk about management constraints. (Despite these management constraints and as the result of laudable efforts, PRIME II carried out its fieldwork in a highly professional and effective fashion.)

At the suggestion of USAID, in 2002, INTRAH began to consider alternative management arrangements that would remove these constraints. It was decided to split INTRAH from the School of Medicine and establish a private, nonprofit entity that would have continued affiliation with UNC. On July 1, 2003, IntraHealth International, Inc. was officially established. All PRIME II activities were/are being transferred to the new organization, including budgeting and accounting. IntraHealth has hired a new chief financial officer and is in the process of setting up a new software accounting system that will afford the flexibility and reporting capability needed. The Internal Revenue Service has now certified IntraHealth as a 501(c)(3) nonprofit agency, which permits the organization to receive funding from any source. IntraHealth is actively seeking new funding from public and private institutions.

USAID Management of PRIME II: Strengths and Challenges

The PRIME project, originally in the Communications, Management and Training Division, was moved to the Family Planning Services Division and is now with the Service Delivery Improvement Division. PRIME II has been under the leadership and guidance of two cognizant technical officers (CTOs) over the term of the project. PRIME is particularly appreciative of the current and former CTOs that have been responsive to

the issues raised by PRIME administration and who sought solutions that were timely and appropriate. A communication method has been developed between PRIME II and the CTOs that works effectively and is valued by both parties.

This relationship did not happen by chance. Both PRIME II and the current CTO have worked hard and made the effort to make this relationship work, which is reflected in the regular discussions and meetings that are held to ensure that both parties are kept informed.

IntraHealth's Performance as Lead Agency on PRIME II

INTRAH has excelled in its role as the lead agency for PRIME II. It has done so despite several important management constraints that are now being resolved.

INTRAH took its role as lead agency very seriously from the outset and structured its plans for the highly successful PRIME II partnership even before receiving the award. Realizing the importance of investing in a good partnership relationship, INTRAH assigned TRG, one of its partners having special team-building experience, with the task of helping to build and make the partnership function well. The result was a model partnership.

An additional important factor in INTRAH'S successful leadership of the PRIME II project was its strategically based approach to new project development and its clear focus on improving the performance of primary providers. Using the performance improvement mechanism, simplified and standardized in PRIME II, and its associated performance needs assessment approach, PRIME was able to gain excellent intellectual understanding and buy-in from partners, USAID, and host country recipient organizations. Having a clear idea about priorities, and supported by two successive supportive and facilitative CTOs in USAID/Washington, PRIME II to a remarkable degree was able to influence the selection and design of its field activities. Unlike several other CA portfolios, PRIME II activities appear to have been strategically selected, well integrated into host country and Mission strategies, and often have potential for expansion of impact. (See also the self-assessment.)

<u>Lesson Learned</u>

- Good portfolios of important project activities in a worldwide project as complex as that of PRIME II do not just happen. They are the result of good project design, informed leadership, a clear project mission, high-quality staff using appropriate tools, a good partnership, and good sustained support from the CTO(s).

<u>Recommendation</u>

- USAID/Washington should study carefully the factors that made PRIME II work so well and attempt to replicate them in future procurements.

Involvement of Other Partners in PRIME II

PRIME II is organized as a consortium of partner organizations. Each organization in the partnership contributes special expertise to one or more of the technical leadership areas and may also complement the skills of other organizations within the working group. The work of the partnership is also enhanced by the participation of two supporting organizations that supplement the capacity of PRIME in the focal areas of maternal and child health. Four partners and one supporting organization have placed full-time staff in the Chapel Hill headquarters office. Some of the PRIME field offices also house partner staff.

The organizations value the partnership and have made it effective through determination and a deliberate and concerted effort. This frame of mind grew from a concern that the partnerships had not worked at optimal effectiveness in PRIME I and that each partner was determined to improve effectiveness in PRIME II.

A memorandum of understanding crafted among the partners at the onset of the project defines the intended nature of the working relationship. A partner leadership group, facilitated by TRG, a partner with technical skills in organizational development, meets regularly throughout the year. The meeting venue is rotated among the partner groups. Attendance is mandatory by one of two designated representatives from each partner. The group discusses redistribution of labor, staff assignments from key partners at IntraHealth's offices in Chapel Hill and some overseas offices, and conducts other team-building exercises.

PRIME administration views the partnership as the key to its ability to promote equal balance, attention paid, and resources dedicated to each of the technical leadership areas. Each technical leadership area is promoted by a technical leadership group, which is comprised of representatives from the partners whose skills and capacities are most relevant to the area's scope of work.

This organizational value has been implemented in the field offices as well. In Armenia, the PRIME II office has partnerships with PADCO (the bilateral organization), International Relief and Development, and the Women's Rights Center (an NGO). In Bangladesh, PRIME II has worked effectively with several organizations involved with NIPHP and the NGO Service Delivery Program. In addition, through the HPSP, PRIME II has worked with the German Technical Cooperation (GTZ), the Department for International Development (United Kingdom) (DFID), and the World Bank. These partnerships have a synergistic effect on the work of PRIME II.

<u>Lesson Learned</u>

- Well-functioning partnerships do not just happen. They require constant attention, care, and investment. However, it *is* possible to foster, nurture, and sustain high-quality partnerships that result in cost savings, effective fieldwork, and a reputation for working well with others. This last is important, as reputation and experience in working well within a partnership makes it easier to work well with important CAs and donor agencies that are not partners.

Recommendation

- PRIME II should be encouraged to write a manual on the care and nurturing of a partnership. The manual should emphasize the critical aspects of a partnership, including agreements of methods of work as well as the procedures established to settle conflict. The partnership memorandum of understanding should be included in this manual. The manual should be made available through USAID/Washington to all partners and those in partnership agreements.

Benefits and Challenges of the Consortium Partnership

PRIME proposes that the benefits of the partnership have been

- the ability to think strategically and collaboratively about new country projects and to respond more quickly to new opportunities because the network of relationships developed by each partner working independently also works to the advantage of PRIME partners working collaboratively;

- the ability to work more efficiently as partner organizations openly share their work products, talents, and expertise to a joint enterprise; and

- important lessons learned about effective methods for reaching out to other organizations that are not formal partners and to involve them in PRIME's work, when their institutional capacity offers added value.

PRIME estimates that the cost of this partnership, reflected as the personnel and travel costs required to sustain the interpersonal discussions, represents a two-year average of 1.5 percent of PRIME's annual budget. PRIME also estimates that a dysfunctional partnership could have an adverse financial impact that would total at least twice the sum invested in the proactive strategy.

Two key informants described this partnership as the model for how partnerships should work. One respondent offered a specific example of a collaborative effort that failed because, in her opinion, insufficient attention was paid to the need for effective interinstitutional communication. There are several instances of partnerships among USAID CAs that did not work well; PRIME appears to be a glowing exception.

Two other informants expressed the opinion that INTRAH, as the lead agency, did not maximize opportunities to share work in the domains in which it believed that it had at least some experience or capacity. It was the stated perception that staff members seconded to the PRIME office were used very well but that the participation of other staff from partner agency offices was not actively solicited. Overall, however, it is clear that the PRIME partnership worked well.

Benefits and Challenges of Regional Offices

PRIME has provided a detailed description of both strengths and challenges of the regional office approach in its self-assessment. The benefits of having four regional offices staffed predominantly with local experts were described in relation to PRIME's ability to respond quickly and effectively to Mission requests on both field support and bilateral programs as well as to forge important relationships and identify opportunities for new and innovative activities. No evidence was found that would question PRIME's statements in this regard.

On balance, it appears that despite some challenges (communication and coordination, synchronizing regional and headquarters' technical assistance, balancing Chapel Hill's priorities with technical leadership areas, and innovation with the Mission's field support and bilateral priorities), the benefits far outweigh the challenges. PRIME notes that two of its partners (PATH and EngenderHealth) have studied its regional model carefully and have determined to implement/reimplement this model for themselves.

Staff Recruiting and Retention in PRIME II

PRIME II has had some staff turnover but this has not been a major issue. The principal change is the project director. However, the new director is an experienced professional and her entry into the team has been positively received and appears to be working well. The former director is still available for consultation as he is leading the new nonprofit organization, IntraHealth International.

At the country and regional levels, most of the staff has remained in place. PRIME II largely relies on the local population to fill positions. However, in both Paraguay and Ghana, there were changes in the chief of party in the early years that caused considerable delays in program startup. The major shift in regional offices is from India to Thailand.

Working With PRIME II: Experiences of Partners, USAID, and Others

PRIME administration and USAID/Washington leadership have established a very effective communication pattern and a strong working relationship. Interviews conducted with USAID/Washington management elicited very favorable evaluations of the technical scope of PRIME II activities, the technical leadership areas that form the framework of the work initiatives, and the results orientation that has been adopted for the monitoring and evaluation of project activities. Concern was expressed that the work of PRIME should continue through some appropriate mechanism in light of the documented effectiveness of global PRIME project activities.

The opinion of USAID Missions, elicited both by e-mail responses to questionnaires and by in-country interviews, were also generally supportive of the work of PRIME, generally aware of the various expertise contributed by the partners, and quite strongly supportive of the management in place at the time of this inquiry (see appendix C). The Mission representatives expressed satisfaction with the mechanisms established for communications with PRIME via the country representative, specifically noting that it was rarely believed to be necessary to communicate directly with the PRIME

headquarters office in order to seek resolution of any issue. Some Missions expressed reservations about the effectiveness of the management of personnel and resources; these responses, in the majority, came from countries in which PRIME had more recently begun work. The work was characterized by these respondents as slow to begin and slow to be expanded. These responses, in the majority, linked to PRIME's insistence on applying the performance improvement approach whenever possible, before developing specific country interventions—an approach that is not always favored by those providing funds for the services.

Representatives from the PRIME partners in countries visited by the team expressed a somewhat reserved opinion about the effectiveness of partnership activities at the country level. Respondents in Ghana indicated that the country director made assertive efforts to maintain open lines of communication and to coordinate the various calendars of activities between and among the agencies. However, the primary focus of each individual agency in both Ghana and Paraguay seemed to be on the individual scope of work contracted with the USAID Mission and a much smaller emphasis on identifying the activities in which the individual agencies could advance a PRIME agenda.

It was most certainly the case in the majority of interviews conducted with MOH representatives that the identity of PRIME was intimately tied to the identity of INTRAH. The organizational interrelationships that comprise the PRIME project were not visible. However, that did not seem to have an adverse impact on the intent to work with a PRIME work agenda, as negotiated with and through its country representatives and PRIME/INTRAH management personnel.

Interviews with respondents that worked indirectly with PRIME (former employees of PRIME partners and external consultants who were engaged occasionally with PRIME work activities) reflected a highly positive view of PRIME administration and management and an overall highly positive evaluation of PRIME's overall body of work. The creation of the partnership leadership groups was viewed as a model strategy for promoting effective intergroup communication. Some reservation was expressed about the actual success in using the expertise of all partner groups effectively.

Greatest Challenges Faced in Implementing PRIME II

The following challenges to the implementation of PRIME II and the actions taken in response to these challenges are discussed in detail in other sections of this report. Some examples are cited here.

- Challenges to effective fiscal management of the project were addressed through administrative reorganization as a nonprofit organization with university affiliation.

- The time-consuming approach of performance needs assessments and performance improvement met with some resistance from Missions with a need for a quick resolution. These difficulties have been overcome by the development of project performance monitoring plans.

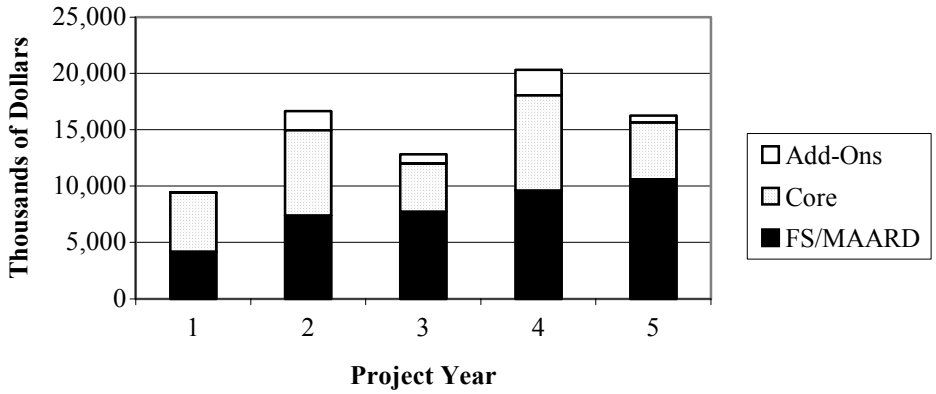
- The challenges to effective communication within PRIME were addressed by the creation of a partnership leadership group, establishment of regional offices, development of technical leadership area groups and regional teams, and strategic use of technology in the communication and information dissemination process.

PROJECT COSTS

Funding Trends Over the Life of the Project

Figure 1 summarizes PRIME II's overall funding trends for each project year. Field support/Modified Acquisition and Assistance Request Document (MAARD) funding forms the basis of PRIME II funding, with some core and special initiatives funding. While core and special initiatives funding varied in each project year, the trend in field support was a substantial increase each year.

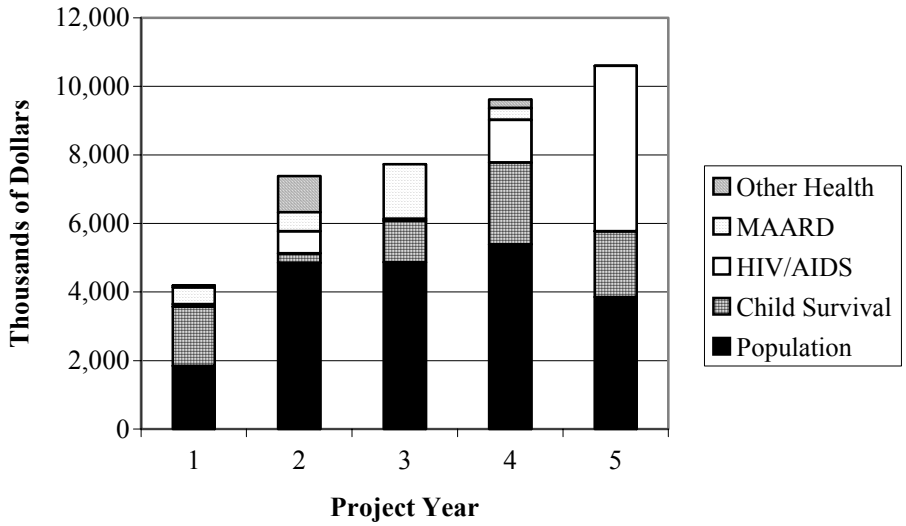
Figure 1
Actual Obligations by Type



Even in the first year of the project, field support/MAARD funding was substantial. This supports the finding that PRIME II startup was in many instances relatively quick for a project of this scope and complexity.

Figure 2 on the following page shows the breakdown of field support/MAARD funding for PRIME II by source of funds. While population funding was important throughout the project, other accounts became increasingly important sources of support, particularly HIV/AIDS in the last two years of the project. The team believes that the growth in overall field support funding reflects the increasing interest of the USAID Missions in services provided by PRIME II, both in RH and other health areas.

Figure 2
Field Support/MAARD Actual Obligations by Account



Clearly, the increased availability of HIV/AIDS funding and the desire of Missions to use this funding effectively have had an impact on PRIME II, no doubt in part stimulating the addition of HIV/AIDS as a new technical leadership area. This is basically a positive outcome as IntraHealth has considerable tools and expertise to bring to bear in this important and especially needy area. (Actual obligation figures underlying the above charts as well as more detailed funding information can be found in appendix I.)

Yearly Increases in Field Support Funding

Performance improvement and training of the primary provider is a critical technical assistance area for every national family planning and reproductive health program. In many cases, the primary provider is the only health worker a woman and her children will see in a lifetime. The work of the primary provider is critical to the overall health and well-being of a population. PRIME II has been successful in this essential area of technical assistance and will continue to be needed as new providers enter the programs and experienced providers require updating of knowledge and skills. Missions recognize this important niche in the training skills area. PRIME II has performed excellently in most countries so the support for its work increases with time.

In addition, PRIME II has packaged training in a new and attractive manner. Instead of the usual training project that consists of lists of training courses, participants, and pretraining and posttraining results, PRIME II has introduced the performance improvement package. Performance improvement is exciting to providers because it incorporates more than a simple training course—it includes the environment and its influences on successful provider work. If carried out fully, performance improvement is a system that includes a needs assessment, fills those needs through training, augments training with facility improvement or the provision of equipment and supplies, and continues following the trainee with supportive supervision. Each aspect of performance improvement is critical to the overall success of providers in fulfilling their duties of

serving clients. Because PRIME II recognizes that each aspect is critical and works to ensure that all aspects are in place, the trainees are having an impact on service delivery.

The advantage of new packaging, such as performance improvement, is that it adds excitement into programs that have been providing training for decades and have been quite set in their ways. PRIME II has proven that performance improvement is a successful way to ensure that providers are well trained, have the environment needed to perform their work, and are mentored. There is also a clear benefit on the number of clients reached for services and their satisfaction with the services they receive.

Field Missions and MOHs are appreciative; therefore, their levels of field support are increasing. The Mission in Armenia noted, "PRIME II's interventions were carefully and effectively designed to support the Mission's and Ministry of Health's strategies." The Dominican Republic Mission commented, "PRIME II interventions were very supportive of the Mission RH strategy, and in a way shaped up the GODR [government's] strategy." The Mission in Benin wrote, "The PRIME II interventions have been replicated at the regional and/or national level. For example, due to the current success of the Emergency Obstetric and Neonatal Care project, the MOH has decided to scale up and replicate efforts, and other donors (UNFPA, WHO) are using the program as a model for their activities."

PRIME has also been cognizant of the emerging health concerns and proposed appropriate revisions to its strategic scope of work in order to position itself to be responsive to specific country needs. PRIME's recent work in female genital cutting (Ethiopia, Kenya, Mali), gender-based violence (Armenia), and active management of the third stage of labor (Benin, Mali, Ethiopia) are examples. The creation of a new technical leadership area in HIV/AIDS (e.g., work recently initiated in Armenia, Benin, Ethiopia, and Rwanda) is another example.

Lesson Learned

- PRIME II has shown that even those programs that have been providing training for decades can still benefit from the performance improvement approach to training.

Value Added by Use of Core Funding

Under the PRIME II cooperative agreement, core funding (exclusive of core funds that are targeted for specific special-interest activities) represents approximately 40 percent of overall funding, or approximately $6.1 million per year. These funds have been used relatively effectively by PRIME in that important activities as outlined below have been funded. The following table depicts core funding as part of the overall project.

Summary of PRIME II Funding to Date (in $ 000s)

Type	Year 1	Year 2	Year 3	Year 4	Year 5	Total
FS/MAARD	4,190	7,380	7,728	9,617	10,604	39,519
Core	**5,250**	**7,560**	**4,285**	**8,427**	**5,020**	**30,542**
Total	**9,440**	**14,940**	**12,013**	**18,044**	**15,624**	**70,061**

PRIME states that the availability of core funding under the cooperative agreement has been extremely useful in furthering the goals of the agreement. The team was unable to examine each core-funded activity closely; it appears that core funding had an important and sometimes pivotal role in making this project a success. Aside from the obvious benefits of facilitating the establishment of strong professional staff based in North Carolina and the regional offices, core funding has contributed the following:

- **Provided important seed money:** Core funding has been used to initiate a new idea when there was no other source of funding available. In several cases, Missions have become quite interested in an effort that began with core funds and then funded a subsequent expanded activity with field support funding (as in Nicaragua and Paraguay). Contributing some core funds is often a good way to integrate a new technical leadership area into a field support project, which may otherwise have a more traditional approach.

- **Allowed for technical leadership, innovation, and risk taking:** Missions are often focused on problem solving and are looking for a quick solution that is known to be effective. They may not be willing to try something new and document how it works. For example, it is doubtful that the performance improvement approach could have been tested and refined to its present degree without core funding. Other examples are PRIME's contributions to the development of the PAC model (with other partners and agencies), testing of the preventing postpartum hemorrhaging model in three countries, and several pilot studies to incorporate consumer feedback.

- **Allowed for improved documentation of successes and learning:** Core funds allowed for stronger monitoring and evaluation under PRIME II to provide evidence about new approaches and for the collection of data needed to make better programming decisions about the interventions and approaches that are best in specific situations. Core funds have allowed for such studies as the *Performance Factor Study* (in three countries) that was designed to help test a method that can be used to determine the performance factor that will yield the higher return in terms of provider performance.

- **Allowed for cross-fertilization and sharing of learning:** Core funding supports a technical core staff to facilitate learning across projects. During PRIME II, countless country projects have benefited from adapting experiences, curricula, tools, or study designs first used in another PRIME project (e.g., the Ethiopia project is now applying learning from Rwanda). Core funds also support the documentation of learning and its dissemination, as with the development of the *Transfer of Learning Guide* and the document for performance improvement practitioners, *Stages, Steps and Tools*.

Core funding under PRIME II has been important and effective in furthering CA objectives. Additionally, PRIME has demonstrated that core funding can be used to achieve important objectives that without such funding would probably not be attained (e.g., performance improvement refinement, monitoring and evaluation system, blended learning approaches, PAC and postpartum hemorrhaging model development).

Recommendation

- To the degree possible within existing funding constraints, USAID/Washington should strive to ensure an adequate level of core funding in future procurements of this type to provide for the benefits described above and should monitor the use of such funds carefully to ensure their effective use.

Cost-Containment Approaches

Project cost containment needs to be viewed on several levels. Cost containment at the organizational/institutional level is a fundamental project management principle and is not well reflected in the response received from PRIME II in the self-assessment. Information can be gleaned from the annual management review documents that were made available to the team.

Cost Containment at the PRIME II Project Administration Level

A number of initiatives were targeted by PRIME II administration as ways and means to work more efficiently and productively. These included

- development of the partnership leadership group to promote high levels of information sharing among the PRIME II partners, with a view to maximizing the potential for the best use of talent and resources inherent in each partner organization that might result in the need for lesser reliance on costly external technical consultant services. The actual financial costs of this partnership were assessed and viewed against the potential costs of ineffective working relationships among the partners (the costs of partnership leadership group activities were identified as 1.5 percent for the first two years of the project, which was considered quite reasonable given the funding generated and possible problems avoided as a result of the effective partnership);

- implementation of core technical leadership groups and regional teams to maintain high levels of intragroup knowledge about activities, projects, and products that might be shared within and among regions, which might lead to materials sharing among similar projects at the country level;

- deliberation about the most strategic placement for regional leadership offices and managers, balancing the relative costs and benefits of Chapel Hill, versus in-country administration of various project activities; and

- assertive development of the methods and strategies used for communication of results within IntraHealth, among PRIME II regions, and with the international community. The volume and variety of publications produced by PRIME II and the quality of the PRIME II web site attest to these efforts. PRIME II has also recently increased its emphasis on the authorship of publications for peer-reviewed literature.

A critical challenge to cost-effective management identified in the earliest years of the project was the manner in which financial accountability for PRIME II was integrated with the UNC accounting system. A number of inefficiencies (e.g., hiring of personnel, procurement of commodities, production of fiscal reports) were inherent in this system, and were outside the control of PRIME II administration. Temporary solutions included such interventions as the formation of a relationship with an export group that had specific expertise in dealing with international procurements. IntraHealth, a nonprofit NGO, was created as the overall solution to this challenge.

Cost Containment at the Individual Country Project Level

PRIME II provides information about methods used to maximize efficiencies and to evaluate costs relative to results obtained at the level of actual work interventions/products, including the following:

- The performance improvement process forms the foundation of almost every country-level work product. The goal of the performance improvement process is to identify the most critical needs for training and nontraining interventions so that the plan of work that emerges from the performance improvement process is targeted and more likely to be efficient in terms of personnel effort and resources needed for implementation.

- There is strong encouragement for sharing and adaptation of materials (e.g., guidelines, curricula, job aids) developed for similar projects. PRIME II also encourages that the work of developing these materials occur in-country whenever possible to maximize the time invested by those who participate in the work as well as to promote ownership of the materials to promote local investments in sustaining the interventions.

- Selected work products have been subjected to cost and results analysis. Current work in progress addresses the relative cost and benefit of alternative learning approaches for providers of safe motherhood services (Ghana). The comparative costs of alternative approaches to the provision of supervisory approaches (self-monitoring, peer support, and traditional external supervision) were studied in Honduras. A number of similar analyses are ongoing (e.g., cost and results analysis of alternative approaches for creating and maintaining clear performance expectations based on policies and protocols in Benin, cost analysis of technology-assisted learning in Kenya, and cost and results analysis of peer support among private nurse-midwives in Kenya).

Lessons Learned

- At the Chapel Hill administrative level, lessons were learned about the critical importance of strategic thinking and strategic planning about internal organizational factors that promote or inhibit the effective management of personnel and resources.

- At the individual project level, within several countries, considerable cost savings were accomplished by building on previous lessons learned in curriculum and materials development.

- PRIME II made best use of the results of outcomes evaluations that supported (or did not support) the effectiveness of these materials in improving provider performance in the workplace and therefore the value of adapting/augmenting these materials into the context of a similar intervention in another country application.

Recommendation

- PRIME should be encouraged to incorporate a cost/results analysis for the majority of its learning approaches and nontraining interventions.

PROGRAMMING

Implementation of the Four Technical Leadership Areas To Achieve the IRs

An aspect of the organization design for PRIME II included the identification of areas of expertise within INTRAH and among the PRIME II partners that would provide a framework for effective communication among all participants and between PRIME II and USAID/Washington. Each technical leadership area is associated with one of the IRs and the appropriate key indicators that are linked to that IR.

Each technical leadership area is led by a global team working under the direction of co-chairs, one representing INTRAH and one representing the PRIME II partner agency that brings the most appropriate expertise to the area of interest. Team members include both U.S. and country-based participants who also have knowledge and skills in the topic area. The team engages in strategic thinking about new initiatives that might be developed (usually with core funding) and tested, then proposed for replication, usually with field funds. Team members contribute knowledge gained from practical experience (what has worked, what should be improved) but also from emerging science (ongoing evaluation work and the published literature). Teams promote their technical leadership area to the other technical leadership area teams and seek to find ways to mesh the scope of interests of two or more technical leadership areas into any single project. It was the expressed opinion of some respondents, however, that "not all technical leadership areas are created equally," and that the actual work of PRIME predominates in the performance improvement scope of interest.

Rationale for the Revision of the Technical Leadership Areas

The establishment of a new technical leadership area, HIV/AIDS and family planning integration, was an appropriate response to the needs of field Missions and programs. It was also, in part, an inclusion of work already being asked of PRIME II in the field. Creation of the new technical leadership area provided the structural framework for projects that would expand the scope of endeavor under PRIME II in a critical, contemporary, work domain.

The factors that underpin the decision to move consumer-driven quality into the context of the performance improvement technical leadership area have been discussed in an earlier section of this report (see section V on IR 4). Briefly, the results of lessons learned about the inherent similarities in the desired outcomes, as assessed by performance indicators established for the performance improvement and consumer-driven quality technical leadership areas, supported the blending of these two work agendas. This change did not mean that consumer-driven quality was no longer attended. In fact, by moving consumer-driven quality into performance improvement (which should be linked), the potential existed to increase attention on consumer-driven quality.

Ensuring Complementarity of PRIME II Approaches

PRIME II has made a conscious effort to complement the activities of other CAs, NGOs, and stakeholders. Responses to the Mission questionnaire indicate that PRIME II does an excellent job of sharing its activities and methodologies with others, including other donors. In Benin, PRIME II developed partnerships with University Research Co., LLC (URC)/Integrated Family Health Program (PROSAF), Population Services International (PSI), Africare, and CARE. In Tanzania, PRIME II worked with the MOH as a partner as well as JHPIEGO and the National Family Planning Association. In Armenia, PRIME II works with Management Sciences for Health's Management and Leadership program as well as the International Relief and Development organization and an NGO, the Women's Rights Center. These sample efforts are indicative of the frame of mind of PRIME II leadership—to develop relationships with other organizations that augment its efforts and multiply the effects of its work. This effort is particularly critical at this juncture as those organizations that have worked in partnership with PRIME II are in a position to continue the work, should they choose to do so.

There are some examples of activities that were not well coordinated, at least in the initial stages of country program development. An alliance partnership established in Paraguay required intervention from the USAID Mission in order to identify the boundaries of activities conducted by PRIME and other CAs within the partnership.

<u>Lesson Learned</u>

- The work of sharing with others has been a centerpiece of PRIME II's work and the effort has been successful in increased dissemination of the performance improvement approach and other methodologies. PRIME II should be commended for this effort as it is time consuming to add sharing to the already considerable work to be done. The fact that PRIME II has taken this aspect of its work seriously gives some encouragement to the idea that the methodologies will be continued by others at the end of the project.

<u>Recommendations</u>

- The methodologies developed through the project, especially the performance improvement approach in all of its facets, should be continued through other efforts in training supported by USAID/Washington.

- PRIME II should be encouraged to compile the lessons learned using the performance improvement approach and to disseminate the document to all organizations involved in training.

VII. FUTURE DIRECTIONS

COMPONENTS OF PRIME II TO BE PRESERVED FOR THE FUTURE

As has been noted throughout this report, PRIME II has been unusually productive, innovative, and promising. The design was excellent—a result of prior experience under the PRIME I contract and exceptionally close collaboration between USAID and the PRIME II team and partners. Implementation—with relatively minor exceptions—has been very strong and virtually all performance monitoring objectives have already been met. USAID Mission receptivity has been high, field support funding has increased annually, and praise for PRIME's work has been plentiful.

For the remainder of PRIME II as well as for the next three to five years, USAID and IntraHealth need to consider ways to safeguard several important components of PRIME II. While there are many positive aspects of PRIME's work, there are six that are most important to preserve and to continue:

- focus on the primary provider;
- key project activities which have potential for major impact, either in the countries in which they are being implemented or for wider application across countries and regions;
- performance improvement/performance needs assessment;
- monitoring and evaluation;
- blended/self-paced learning approaches; and
- the PRIME II partnership model.

Focus on the primary provider has proven to be an excellent strategy for achieving results in improving service delivery. This focus needs to be reflected in the USAID project portfolio as it helps concentrate efforts on what is the outcome: the effective and efficient delivery of RH services.

Key project activities having potential for major impact include those contained in appendix J. This list is illustrative, not exhaustive. PRIME should examine all of its projects closely to determine which are the most important (i.e., have the greatest potential for a large impact) and estimate the time and cost needed to expand the impact of each. (Also in appendix J is a listing of results anticipated in each project during 2004.)

Performance improvement/performance needs assessment, as developed during PRIME II, represents the adaptation, simplification, and effective marketing of **a logical troubleshooting and strategic planning process** with demonstrated acceptability and impact. Where PRIME has been able to implement the entire performance improvement package, there has been an impact on service delivery as well as replication and modeling

by others. USAID and PRIME need to preserve and attempt to broaden the use of this important tool by other CAs and donors. This might be done by charging PRIME with the responsibility to document its approach and share it with selected others. Performance improvement/performance needs assessment as performed under PRIME II is not a process that can be followed by rote. Part of its appeal and its success stems from the cooperative frame of mind of the PRIME partners in working well with others and their willingness to be flexible as needed in individual situations.

Monitoring and evaluation as executed under PRIME II can be seen as a model for others to emulate. Its success factors include strong monitoring and evaluation leadership, a global vision, excellent planning and analytical skills, investment in staff skills needed for decentralized implementation, and availability of core funds to support research and analysis activities that were not always the priority of USAID Missions. PRIME needs to continue its work with other organizations in standards development, and USAID needs to take note that monitoring and evaluation functions in a global action project such as PRIME can be performed effectively if given sufficient leadership, direction, and funding.

Blended/self-paced learning, while not unique to PRIME, has nevertheless been particularly well implemented in this project. The development and use of high-quality distance learning materials, testing of various classic and unconventional learning methods, and the attempt to quantify the effectiveness of particular approaches in particular situations needs to be carried out somewhat further. Coupled with PRIME's research on nonlearning factors related to job performance, this work could help identify optimal learning and nonlearning intervention packages to maximize job performance.

The PRIME II partnership model serves as a standard for future partnerships. Lessons learned here need to be applied where possible to future USAID procurements, both to make them work better and to realize the cost savings associated with a good partnership arrangement.

Recommendations

- **Changes to the basic project design are not recommended.** The project is successful as is; there is no reason to change it.

- PRIME recently added HIV/AIDS as a new technical leadership area. HIV/AIDS is becoming an increasingly important activity in PRIME II, representing some 9.7 percent of funding overall and 30.8 percent in the fifth project year. PRIME has a great deal to bring to bear in this important new programming area that could help rationalize programming in this challenging and challenged area. **PRIME should continue its work in integrating HIV/AIDS and RH services but should strive to achieve a balance and not let HIV/AIDS detract from other important RH activities.**

- **USAID/Washington should reconsider its decision to end this initiative with PRIME II in September 2004**, particularly as there appear to be no ready alternatives to provide this type of assistance. Performance

improvement and comparable training work with primary providers is not being performed systematically in other CA programs. The new ACQUIRE project does not appear to be written to continue this important work (even though a large percentage of its funding is for "improved performance of service delivery providers" and "strengthened environment for RH/FP service delivery" and even though IntraHealth is a partner in ACQUIRE). The loss of the PRIME II partnership and all of the skills each partner brings will limit the effectiveness of ACQUIRE to provide the performance improvement, performance needs assessment, and supportive supervision approach. Even where Missions decide to continue PRIME activities, the timing problems attendant to bilateral organizations and Leader With Associates contracts (including the need to have Mission contracting officers in agreement) will almost certainly mean that some key PRIME activities will have to terminate before realizing their maximum potential.

RECOMMENDED CHANGES TO MANAGEMENT INTERFACE BETWEEN PRIME AND USAID

- It is critical to have continuity of the CTO. The support and overall communication with the present CTO (as well as the former one) are highly appreciated by PRIME II and have helped make this project successful. **For continuity as well as to maintain excellent communication, the CTO should remain the same.** The processes that have been set up to work together, including the frequent meetings, should continue.

APPENDICES

A. SCOPE OF WORK

B. PERSONS CONTACTED

C. MISSION RESPONSES

D. COUNTRY SUMMARIES

E. PRIME II SELF–ASSESSMENT QUESTIONS

F. PRIME II COUNTRY PROGRAMS BY REGION

G. SUMMARY OF RECOMMENDATIONS

H. PERFORMANCE FACTORS BY PROJECT FOR PRIME II

I. SUMMARY OF PRIME II FUNDING TO DATE

J. EXAMPLES OF EXPECTED RESULTS FROM CONTINUED PRIME II WORK

K. REFERENCES

POPULATION TECHNICAL ASSISTANCE PROJECT

1101 Vermont Ave., NW Suite 900 Washington, DC 20005 Phone: (202) 898-9040 Fax: (202) 898-9057 www.poptechproject.com

APPENDIX A

SCOPE OF WORK
(from USAID)

Evaluation of PRIME II
Final Scope of Work

Reviewing Progress and Impact
Making Recommendations for Future USAID Action

August 18, 2003

Background

PRIME II is implemented by IntraHealth International, Inc. (herein after referred to as IntraHealth); cooperative agreement number HRN-A-00-99-00022-00. PRIME I was a contract and PRIME II is a five-year cooperative agreement. The agreement included a one-year base period and a four-year option period. The base period was effective September 30, 2000, and was authorized at a funding level of $15,228,411. The option period was effective October 1, 2000 and ends September 30, 2004 at a funding level of $88,167,768. The following is funding through fiscal year 2003:

Core	$30,422,000
Field Support	$36,259,934 (both committed and obligated)
Add-Ons	$2,991,807
Total	**$69,673,741**

PRIME II is unique among USAID's service delivery projects. For example, EngenderHealth and JHPIEGO are USAID cooperating agencies with missions similar to PRIME. EngenderHealth focuses its work on clinic-based reproductive health service delivery, with special attention to family planning, especially long-term methods. While organized around a clinically-focused niche, their cooperative agreement permits the flexibility to address related services such as PAC and STI/HIV prevention through proven approaches such as quality improvement and male involvement. JHPIEGO's Training in Reproductive Health III cooperative agreement's mission is to train medical and other health care professionals via preservice and in-service. However, PRIME II is different in several ways. The focus of PRIME II is to improve the performance of the primary provider. In some cases, there are private sector nurse midwives; in other instances, it includes public sector obstetrician-gynecologists, or other cadres. Also, while PRIME II recognizes training as a needed and useful intervention, it also emphasizes non-training interventions and their relationship to performance.

Since 2000, PRIME II has carried out a program to strengthen primary-level family planning and reproductive health service delivery in 26 countries. With USAID support,

PRIME II has developed its capacity and reputation as an international leader in the field of training, performance improvement, and post-abortion care. PRIME II is a consortium model, drawing on the collective field experience of its partners: Abt Associates, EngenderHealth, Program for Appropriate Technology in Health (PATH), and Training Resource Group, Inc. (TRG). Save the Children and the American College of Nurse Midwives (ACNM) serve as supporting institutions. PRIME II has regional offices in Senegal, Kenya, Thailand, and the Dominican Republic. The Europe/Eurasia and Northern Africa regions are managed from Chapel Hill.

PRIME II contributes specifically to the Global Health Bureau's Office of Population Training Results Package, "Improved Provider Performance and Sustainable, National Systems for Training and Education in Family Planning and Reproductive Health" **(Attachment 1)**.

The Intermediate Results addressed include:

- IR 1 - Strengthened pre-service education, in-service training & continuing education systems;
- IR 2 - Improved management support systems;
- IR 3 - Improved policy environment; and
- IR 4 - Better informed and empowered clients and communities.

The overall goal of the cooperative agreement is to improve family planning and other reproductive health care that primary-level service providers offer their clients. PRIME II divides their portfolio into four Technical Leadership Areas (TLAs):

- Responsive Training and Learning (RTL)
- Performance Improvement (PI)
- Post abortion Care (PAC)
- HIV/AIDS and Family Planning Integration

Consumer Driven Quality (CDQ) was one of the four TLAs until July 1, 2003. PRIME II and their partners made a strategic decision to move CDQ activities into PI and created a new TLA, HIV/AIDS and Family Planning Integration.

Until July 2003, PRIME II was implemented by the University of North Carolina at Chapel Hill. However, in an effort to streamline operations, a new entity, IntraHealth International, Inc., was created. Effective July 1, 2003, PRIME II became a project within IntraHealth while the University of North Carolina at Chapel Hill became a subsidiary. This activity has required management changes at headquarters.

Purpose of the Evaluation

The purpose of this Evaluation is to assess the performance of PRIME II and provide guidance to USAID regarding the design of future projects. Specifically, the Evaluation Team is expected to:

- Assess the progress made in achieving the four intermediate results; and
- Identify lessons learned and future programming needs.

The team will donate approximately 75 percent of its effort to evaluating PRIME II and 25 percent of its effort to making recommendations for future USAID-funded interventions.

Existing Performance Information Sources

The following documents pertaining to PRIME II's performance will serve as background information for the Evaluation Team. These sources of information include but are not limited to:

A. Documents

- PRIME II Cooperative Agreement and Proposal
- PRIME II Project Authorization
- PRIME II Annual Work Plans
- PRIME II Annual Reports
- PRIME II Service Statistics Reports
- PRIME II Management Reviews
- Select PRIME II Publications
- PRIME II Consortium Meeting Summary Papers
- Global PAC Evaluation
- PRIME II Country Program Evaluations
- Training Results Package Framework
- PRIME II Project Description
- PRIME I Contract Evaluation

USAID will provide the Evaluation Team with one copy of each of the above documents.

B. Site Visits

- USAID/W
- PRIME II Chapel Hill offices
- PRIME II Countries/USAID Missions: Paraguay, Ghana, Armenia, Bangledesh.

C. USAID Missions with PRIME II activities

- Questionnaire results

D. PRIME II Self Assessment

Questions to be Addressed

Attachment 2 identifies specific evaluation questions and to whom they should be addressed. Additional questions and issues may be added by the Evaluation Team. The Evaluation Team, with SDI staff, will prioritize the questions in advance.

Methodology

A. Self-assessment

PRIME II will prepare a self-assessment based largely on the questions in **Attachment 2,** and the report will be provided to the Team as part of the background materials. These questions will be sent to PRIME on August 4, 2003.

B. Assignment Work Plan

A five-person Evaluation Team will initially meet with USAID/W Service Delivery Improvement Division (SDI) staff to develop the overall final Assignment Work Plan. This will include defining the responsibilities of individual Team members, agreeing on a schedule for specific activities **(Attachment 3),** developing a questionnaire for the field survey, field visits, and other operational and logistical issues as needed.

C. Interviews

In continuing consultation with SDI, the Evaluation Team will interview selected USAID/W staff, PRIME II staff, PRIME II Regional Office Directors, partners, missions, other development organizations that work in the area of training and FP/RH, as well as other stakeholders **(Attachment 4)**. In most cases, it is expected that interviews with USAID/W and PRIME II partner staff will be conducted in person. Telephone interviews will be done where face to face interviews are not possible.

A field survey will be conducted using the questions in **Attachment 2.** The Evaluation Team will develop a questionnaire from these questions that will be e-mailed to all missions with PRIME II activities on August 25, 2003.

D. Field Visits

The preliminary plan is to have the team travel to Paraguay, Bangladesh, Armenia, and Ghana. The final selection of the countries will be made based on concurrence by the selected USAID missions, as well as consultations with PRIME staff. The team will also have the opportunity to conduct interviews with key informants, including sub-grantees and other cooperating agencies, to assess the extent to which past results and lessons learned have been incorporated into programs.

The rationale for country selection is:

- Large core/field support funding;
- Countries from each of the four regions; and
- The four TLAs are represented.

Deliverables

A. Evaluation Report

After collecting the information, the Evaluation Team will analyze and synthesize conclusions that address the key questions **(Attachment 2)**. The Team will prepare a report that includes a comprehensive executive summary and is a maximum of thirty pages plus attachments. This report will describe evaluation methods used and present conclusions and recommendations of the Team regarding the key questions. The report will be reviewed first by USAID/W, and then shared with PRIME II. PRIME II will provide comments to the Evaluation Team, who will decide if they will be incorporated into the final document. The Evaluation report will be posted on the USAID public web site. A second document of no more than ten pages will be developed by the Evaluation Team with recommendations regarding future procurements that will be for internal USAID use only.

B. Debriefings

The Evaluation Team will provide a draft report the day of the debriefings. The Evaluation Team will first debrief PRIME II at POPTECH, and then debrief USAID at USAID/W. The team will perform a "dry run" of their presentation with SDI staff before the USAID presentation.

Team Composition

The Evaluation Team must be qualified to make a wide range of possible recommendations, and be sufficiently respected and influential, so that its recommendations will be considered authoritative. It is expected that four consultants with complementary knowledge in this field will be sufficient for the Evaluation Team. In addition, it is possible that a USAID staff member, such as a NEP (New Entry Professional), or other Global Bureau staff member who is not involved in the daily management and decision-making process for PRIME II, will be available to work with the Evaluation Team as an adjunct member. The consultants should have expertise in the following areas:

A. Team Leader

- Advanced degree in public health;
- Previous experience evaluating USAID-funded programs;
- Management experience;
- Good interpersonal team skills;

- Excellent facilitation skills; and
- Strong writing skills.

B. Clinical Specialist

- MD, RN, or nurse mid-wife;
- Expertise in clinical training;
- Clinical experience in developing countries; and
- Expertise in FP/RH, PAC, and/or HIV/AIDS.

C. Training Specialist

- Knowledge of adult learning, training systems and methods
- Expertise in performance improvement;
- Advanced degree in public health; and
- Strong writing skills.

D. Management and/or Measurement & Evaluation Specialist

- Expertise in management
- Expertise in M&E
- Advanced degree in public health; and
- Strong writing skills

E. Overall Qualifications of the Team

- Language capacity a plus; and
- Previous experience evaluating USAID programs desirable for all members (required for the team leader).

Scheduling and Reporting

The Evaluation Team consultants should be identified and recruited as soon as possible. Interviews with key informants will begin the week of September 15th followed by field visits beginning the week of September 22nd. A preliminary report will be forthcoming the third week in October, followed by the final report in mid-December. Interviews will take place in Washington and Chapel Hill, lasting one day and three days respectively. The Evaluation Team will travel in smaller teams to the overseas sites chosen. The final debriefings will occur at POPTECH for PRIME II staff and at USAID/W, each consisting of a short PowerPoint presentation followed by Q&A, lasting about one-and-a-half hours.

APPENDIX B

PERSONS CONTACTED

PERSONS CONTACTED

ARMENIA

U.S. Agency for International Development (USAID)
Edna Jonas, Senior Technical Advisor
Greg Koldys, Democracy and Governance Officer
Kathleen McDonald, Director, Democracy and Social Reform Office
Nancy Nolan, Consultant
Keith Simmons, Director, USAID Armenia

PRIME II
Karina Bagdasarova, Lori Marz Coordinator
Mikayel Grigoryan, Director of Finance and Administration
Hayk Gyuzalyan, Monitoring and Evaluation Specialist
Lilit Hovakimyan, Clinical Advisor
Rebecca Kohler, Country Director
Irene Sargsyan, Gender and Media Coordinator

Clinical Training Sites
- Sonya Arushanyan, Director, Polyclinic 4
- Aram Avalyan, Director, Vanadzor Maternity Hospital
- Anahit Hakobyan, Director, Spitak Mother and Child Center
- Alla Sargsian, Neonatalist
- David Shahverdyan, Ostetrician/Gynecologist, Maternity Department, Vanadzor Hospital 1

Training Sites
- Grigori Grigoryan, Ostetrician/Gynecologist, Maternity Department, Stepanavan Hospital
- Kim Hovhannisyan, Gargar Rural Ambulatory
- Marine Lambaryan, Mets Parni Health Center
- Nune Shahinyan, Pushkin Health Post
- Zhenya Simonyan, Sarahart Feldsher Acoucher Post (FAP)

National Trainers
- Alla Avetisyan
- Ara Dadivanyan
- Armine Nikoghosyan
- Lucine Piloyan

Ministry of Health
Razmik Abrahamyan, Advisor to the Minister for Reproductive Health and Director, Center for Perinatology, Obstetrics and Gynecology
Gayane Avagyan, Reproductive Health Specialist
Tatul Hakobyan, Deputy Minister of Health
Karina Seribekyan, Head, Maternal and Child Health Unit
Rusanna Ushbashyan, Head, Primary Health Care Unit

Abt Associates
Vardan Abovyan, Armenia Social Transition Project
Nancy Fitch, Primary Health Care Advisor

Women's Rights Center
Armine Nikoghosyan, Psychologist
Susanna Vardanyan, Director

Other Contacts
Robert Dilbaryan, Director, Lori Marz Health Department
Donara Hakobyan, Director, Basic Medical College
Samvel Hovanissyan, Director, Family Medicine, National Institute of Health
Micheal Narimanyan, Director, Family Medicine, State Medical University
Mariam Sianozova, Director, International Relief and Development

BANGLADESH

USAID
Kishan Chakravorty, Population and Health Team

National Integrated Population and Health Program (USAID)
Merina Adhikary
Ahmed Al-Kabir, John Snow, Inc.
A.J. Faisel, Country Representative, EngenderHealth
Ubaidur Rob, Country Representative, The Population Council
Shalini Shah

PRIME II
Jim McMahan (North Carolina Staff)

Government of Bangladesh

Health and Population Sector Program
Golam Ahad, National Consultant, Performance Training
Kazi Belayet Ali, National Consultant, Performance Evaluation
Nazrul Islam, National Consultant, Training Management Information System
Aftab Uddin, Senior National Consultant, Program Management

GHANA

USAID
Juliana Pwamang, Program Specialist, Reproductive Health
Jane Wickstrom, Senior Technical Advisor, Reproductive Health/Family Planning

PRIME II
Edward Bonku, Training Specialist
Isabella Rockson, Program Associate, Monitoring and Evaluation
William Sampson, Country Director
Janet Tornui, Community-based Health Planning and Services (CHPS) Technical Officer

Ghana Health Services (GHS)
Patrick Aboagye
James Akpabilie
Frank Nyonator
Ken Sagoe

Ghana Registered Midwives Association (GRMA)
Kathlyn Ababio
Matilda Bannerman-Wulff
Dora Komladzei-Amoyaw
Midwives

The Population Council
Tanya C. Jones
L. Placide Tapsoba

Other Contacts
Community Health Officers
Emmanuel Fiagbey, Johns Hopkins University/Center for Communication Programs
Abigail Kyei, JHPIEGO
A. Nignpense, EngenderHealth
Regional Resource Team Members

PARAGUAY

USAID
Graciela Avila, Health and Population Officer
Josceline Betancourt, Health and Population Officer
Sergio Guzman, Deputy Director
Wayne Nilsestuen, Director

PRIME II
Felicita Aranda, Technical Supervisor
Angela Espinola, Caaguazu Project Coordinator
Gregorio Soriano, Country Director
Jorge Sosa, Master Trainer
Lilliana Villalba, Finance Manager
Elodia Vysokolan, Program Officer

Encarnación Regional Hospital
Maria Teresa Baran, Director
Aida Palacios Burges, Chief Nurse

Fram District
Jose Rolon Pose
Hermalinda Rojas

PRIME Caaguazu
Digna Britez, Coordinator, Community Activities
Dolly Godoy, Staff Member

Other Contacts
Cynthia Prieto, Centro Paraguayo de Estudios de Población (CEPEP)
Augustin Carrizosa, Centro de Información y Recursos para el Desarrollo (CIRD)
Carmen Sorilla de Ramirez, San Miguel

UNITED STATES

USAID
Jim Griffin, Cognizant Technical Officer, TAACS II Project
Jim Shelton, Service Delivery Improvement Division
Pamela Mandel, Service Delivery Improvement Division
Mary Ellen Stanton
Vic Barbiero

PRIME II and Partner Organizations
Lynn Bakamjian, EngenderHealth
Karen Blyth
Mona Byrkit
Wilda Campbell, Abt Associates
Anne Lion Coleman
Kristin Cooney
Maureen Corbett
Susheela Englebrecht, American College of Nurse-Midwives (ACNM)
Alfredo Fort
Pape Gaye
Steve Hicks
Linda Ippollito
Roy Jacobstein, EngenderHealth
Bill Jansen
Marc Luoma
Jim McCaffrey
Barbara O'Hanlon, Consultant
Laurie Parker
Margaret Rabb

Mary Scott
David Shanklin
Ann Wilson, Program for Appropriate Technology in Health (PATH)

Other Contacts
Harut Sassounian, President and Chief Executive Officer, United Armenian Fund
Rick Sullivan, JHPIEGO

APPENDIX C

MISSION RESPONSES

MISSION RESPONSES

ARMENIA

1. **Implementation Results:** *Were the PRIME II interventions in your country useful in improving the effectiveness of targeted service providers? Please explain. If there is as yet no objective measure of this, please provide your best judgment as to whether the interventions have or will improve service delivery outcomes.*

It is our expectation that the performance improvement and training interventions now in progress will be very effective in improving the services provided by reproductive health care providers in rural areas. Because the interventions are based on findings from the baseline performance needs assessment and gap analyses carried out jointly by PRIME II and the Ministry of Health, we are confident that the interventions are appropriate to meeting the identified needs of service providers. PRIME II is actively monitoring the implementation of the training program and addressing any issues that may arise.

2. **Scale and Importance:** *Have the PRIME II interventions been replicated at the regional and/or national level? If PRIME activities were scaled-up, what has been your experience with scale-up?*

PRIME II has been working in Armenia for 2 years and is in the midst of implementing the first round of training and other program components. Therefore, replication of project interventions to other parts of Armenia or nationally has not yet been planned.

3. **Strategic Fit:** *Were the PRIME II interventions in your country specifically designed and tailored to support the Mission strategy? The government strategy?*

PRIME II's interventions were carefully and effectively designed to support the Mission's and Ministry of Health's strategies. The Mission's priority is system strengthening/institutional capacity building for the MOH, regional health authorities, and health facilities. PRIME is playing a key role in these efforts. Both the government and Mission have also prioritized primary health care and PRIME has effectively aligned its activities to support and enhance other USAID–supported programs that are focused on strengthening primary health care service delivery.

4. **Management of Resources:** *How has PRIME II managed its personnel and resources in your country?*

To our knowledge, there have been no problems in managing in-country/local personnel or its financial resources. There have not been any lags in project implementation due to personnel or resource management problems. Project implementation and spending have proceeded at an appropriate pace.

5. **Timeliness, Technical Approach, and Style:** *Please comment on PRIME II's technical proficiency, timeliness, and cultural appropriateness.*

Both locally based expatriate and Armenian staff and headquarters staff appear highly qualified and have been proficient in carrying out their roles and responsibilities. The Armenia country director has done an excellent job of managing the multicomponent Armenia program. Since her arrival in Armenia in late April 2002, project implementation has proceeded at a good pace.

PRIME II/Armenia has used the performance improvement methodology/framework. This has enabled stakeholder involvement in all phases of program planning and implementation and has been a useful tool for building consensus on program priorities and activities.

6. **Collaboration with Partners:** *How well did PRIME II coordinate with its consortium partners[1] in providing needed assistance? How well did PRIME II collaborate with in-country CAs/organizations and local government institutions?*

PRIME II/Armenia effectively used staff from its consortium partners, TRG, ACNM, Abt Associates, and PATH to assist in project implementation of the following program components: performance needs assessment: TRG and ACNM; provider training: ACNM; national reproductive health policy: Abt; gender-based violence: PATH; and strengthening human resource management and supervision systems: TRG.

The country director and the local PRIME II staff as well as headquarters staff members who have visited on TDY have been able to establish effective working relationships with governmental counterparts, other USAID implementing partners, donors, and international organizations working on similar issues. PRIME II/Armenia developed and signed a memorandum of understanding with International Relief and Development/Armenia to ensure that training provided by PRIME will include rural health providers from IRD project sites and that IRD will supply needed pharmaceuticals for health facilities in which PRIME is working. PRIME/Armenia is also working closely with PADCO/Abt Associates in developing the reproductive health component of the new family medicine training/education curriculum and will implement the reproductive health component of inservice training for family medicine physicians.

7. **Positive Outcomes:** *What were the most positive outcomes of PRIME II's work in your country?*

To date, the most important outcomes of PRIME II's work in Armenia have been building national consensus on newly defined roles for nurses working in rural health facilities and development of new national standards on infection prevention and control for reproductive health providers.

National counterparts appear to be very pleased with the training program for rural nurses that is currently being implemented and with the work on updating national STI prevention and treatment guidelines that has only recently begun.

[1] Abt Associates, EngenderHealth, PATH, TRG, ACNM

8. Challenges and Constraints: *What didn't work out so well? Why?*

There was only one project activity that did not seem to meet government expectations. The Ministry of Health had requested PRIME II assistance in updating the National Reproductive Health Policy document. PRIME/Armenia used a health policy expert from its partner, Abt Associates, to respond to this request. Although the TDY of the Abt staff member produced a very appropriate plan, in the Mission's opinion, for building national consensus for a new reproductive health policy, this was not what the ministry had hoped for. However, the ministry was not able to clearly articulate its expectations to either PRIME or USAID.

9. Future Directions: *What should be done better in the future regarding the performance of the primary provider?*

The current approach has been very effective. However, the drafting of training curriculum for use in-country is an activity that could be modified to better build local capacity and ensure sustainability. Currently, PRIME II uses headquarters staff to draft the training modules, after agreement on content has been reached with local counterparts. It would be beneficial if counterparts were more involved in the actual drafting of the training materials.

I would also like to see PRIME strengthen/expand its capacity to disseminate and facilitate implementation of national policies at the local level.

In a possible follow-on global cooperative agreement or contract, what would you like to see that better supports Mission needs?

The current program was very flexible and effective in meeting the Mission's needs.

What was missing under the existing arrangement?

There are no apparent omissions.

What could have been foregone?

There did not seem to have been any activities or components implemented in Armenia that did not address issues mutually agreed upon between PRIME II, the Mission, and the government.

10. Additional Comments: *Please add any further comments you'd like to make regarding PRIME II's work in your country…past, present, or future.*

We have no additional comments.

Thank you most sincerely for your responses and insights.

BANGLADESH

1. **Implementation Results:** *Were the PRIME II interventions in your country useful in improving the effectiveness of targeted service providers? Please explain. If there is as yet no objective measure of this, please provide your best judgment as to whether the interventions have or will improve service delivery outcomes.*

From May 2000 to June 2003, USAID supported PRIME II to provide technical assistance to the Health and Population Sector Program (HPSP) to implement the government's inservice training strategy. The project had two principal objectives: (1) strengthen the capacity of the Technical Training Unit, which is responsible for planning and managing the training of nearly 100,000 health and family planning service providers on the essential services package, and (2) strengthen five lead training organizations to plan, organize, and conduct training of trainers for Upazila (subdistrict) level trainers, who are responsible for conducting actual training of field-level service providers.

PRIME developed necessary performance monitoring systems and tools for both trainers and trainees and trained Technical Training Unit and lead training organization staff on using the tools. With PRIME's technical assistance, baseline and end-term surveys were conducted on some selected indicators. Some of the important findings are discussed below.

Lead Training Organizations that Meet National Quality Standards for Training: The performance needs assessment conducted in 2001 shows that none of the six lead training organizations met the criteria of satisfactory performance on 85 percent (cut-off point) of critical training tasks. The performance needs assessment in 2003 indicates that all six lead training organizations have achieved the desired performance level.

Trainers' Performance to Standard: Follow-up data from the training management information system (TMIS) shows that 83 percent of the trainers assessed in the classroom were performing to standard. It also shows that 50 percent of the trainers performed to clinical standard. No baseline data are available for comparison. However, the target for FY 2003 was 80 percent for classroom performance and 50 percent for clinical performance.

Performance of the Service Providers: A set of criteria was used to measure work-site performance of the family welfare visitors and health assistants that run the community clinics. Data were collected through the observations method using a checklist. The end-term findings show that 37 percent of family welfare visitors and health assistants are performing to standard (compliance with 85 percent of the criteria used). This was only 10 percent at baseline.

2. **Scale and Importance:** *Have the PRIME II interventions been replicated at the regional and/or national level? If PRIME activities were scaled-up, what has been your experience with scale-up?*

One of the PRIME II interventions was the establishment of a TMIS at the national level for planning and monitoring training and evaluating providers' performance. Later, at the request of the Technical Training Unit, PRIME developed and set up a similar system,

the district Managing Information System (DMIS) for use at the district level in an effort to decentralize the training management responsibilities. PRIME initially set up the system in three districts on a pilot basis and trained relevant staff to use the system. Afterwards, the Technical Training Unit installed the DMIS in seven more districts with partial technical support from PRIME. The Technical Training Unit is now working on a plan to expand the system to 24 more districts with IDA funding support.

As a special initiative, PRIME introduced its performance improvement model for improving service providers' performance at three upazilas of Bangladesh. The government of Bangladesh has now planned to scale up the initiative in six other districts. The Technical Training Unit staff trained on the model will implement the plan using its own resources.

It is my experience that district-level staff found DMIS a user-friendly system effective for better human resource management. The system has been acceptable because minimum staff time and basic computer skills are all that are needed to operate the system. Similarly, the field level staff liked the performance improvement model as it is simple to use and encourages participation of all levels of staff to improve its performance as a team. However, it is my observation that the level of support from top management to sustain this sort of new initiative diminishes with the lapse of time. There is no incentive and recognition from top management for the workers to carry out the additional responsibilities needed to continue these efforts.

3. **Strategic Fit:** *Were the PRIME II interventions in your country specifically designed and tailored to support the Mission strategy? The government strategy?*

Strengthening capacity of training organizations to enable them to provide quality training per accepted training standards for improving knowledge and skills of service providers is one of the PHN objectives. This is also the primary objective of the government's inservice training strategy. PRIME's technical assistance directly supported *this objective.*

4. **Management of Resources:** *How has PRIME II managed its personnel and resources in your country?*

The PRIME II project in Bangladesh was designed to assist the Bangladesh government to implement the inservice training strategy. About 100,000 health and family planning service providers had to be trained in the essential services package, which the government wanted to introduce in its program. Everything had to be started from scratch because not even the required management structure was in place to carry out this challenging task. In this context, PRIME had a difficult job to set up new systems, guidelines, and tools for planning, managing, and monitoring the different training management activities. They had to work closely with different government and nongovernmental organization (NGO) entities for this purpose. This demanded comprehensive and continuous assistance from PRIME to implement its primary objectives as mentioned under question 1. In addition, PRIME made extra effort for its special initiative to demonstrate the usefulness of the performance improvement model and DMIS at the field level. Given the limited support from USAID, PRIME was under pressure to manage the project with four locally hired consultants, two expatriate

consultants in the Dhaka office, and occasional technical support from its regional and central offices. One expatriate staff left the position after a year, but that key position was not filled again. However, PRIME was able to complete all its planned activities in a timely manner through efficient and effective use of its personnel and other resources.

5. **Technical Approach and Style:** *Please comment on PRIME II's technical proficiency, timeliness, and cultural appropriateness.*

PRIME worked in collaboration with different partners and needed outside consultants to carry out many activities. It has successfully implemented all activities identified in its annual work plans, always in a timely manner.

PRIME's technical approach and management style were driven and adapted by a thorough understanding of its desired work objectives and the complex environment of the government for which it worked. During the three-year period, I have met and worked with a number of technical experts, who came on short visits. Their technical proficiencies were excellent in most cases. One unique example is the inservice training strategy itself, which was developed by one visiting consultant in about a month's time. This strategy outlined the needed management structure and implementation mechanisms for providing inservice training. The World Bank, Bangladesh government, and USAID have equally appreciated the high quality of this document, which is now the basis of all government inservice training programs.

PRIME's team approach to developing systems and resolving problems in a participatory management style has always been appreciated by all of its partners, including USAID. Personally, I have found the management style to be sharing, supportive, adaptive, and responsive.

6. **Collaboration with Partners:** *How well did PRIME II coordinate with its consortium partners in providing needed assistance? How well did PRIME II collaborate with in-country CAs/organizations and local government institutions?*

It's difficult for me to comment on how well PRIME II had coordinated with its consortium partners. They brought in technical experts from their partners as suited for the job to be done. USAID was not formally consulted on that. But in retrospect, I can say that most of the technical people who came to work here were found to be proficient in their technical field.

PRIME collaboration with the Bangladesh government, training institutions, and other international donor agencies was fairly good. As a matter of fact, PRIME would have found it difficult, if not impossible, to carry out many of its activities unless it had good collaboration with its government counterpart and other stakeholders. Every year PRIME shared its annual work plans with the Technical Training Unit and other donor agencies in order to get their opinion and to avoid duplication of efforts. Timely completion of curricula development, organizing essential services package training in coordination with different stakeholders, and district-level training organizers are indicative of PRIME's effective collaboration at all levels.

7. **Positive Outcomes:** *What were the positive outcomes of PRIME II's work in your country?*

The development of the national training guideline is one of the important outcomes of PRIME's intervention here. The Bangladesh government has approved this guideline to be used for planning and managing all government training programs. Previously, all government inservice training was planned and conducted without any systematic approach to ensure the quality of training and to achieve desired training objectives. This guiding document has met a critical need and is expected to significantly improve the quality of inservice training for the health and population service providers.

The development and installation of the TMIS is another important outcome. The system will greatly improve the development of training plans and monitor the quality of training sessions and performance of trainees, providing feedback and support to continuously improve providers' performance.

The introduction of the performance improvement model at the field level may also be considered as a positive outcome. PRIME had several constraints in terms of financial and human resources and duration of the initiative as needed to demonstrate the effectiveness of this model to improve performance through local level planning. However, the service providers and their supervisors, who participated in performance improvement sessions, showed genuine interest in this model and found it useful. Realizing the benefit of this approach, the Technical Training Unit has planned to expand this model to several other districts using funding support from other sources.

8. **Challenges and Constraints:** *What didn't work out so well? Why?*

PRIME's main objective was to strengthen the Technical Training Unit to plan and manage quality training for service providers. It could not implement all of its planned activities in the desired manner for several reasons. The main constraint was to ensure the availability of funds for the planned activities because the Technical Training Unit had a lot of problems to access IDA funds, which supported the government HPSP. Vacant positions in the Technical Training Unit and transfer of key personnel also caused major interruptions in implementation of activities in a timely manner. Besides, the government put great pressure to complete all training within an unrealistic short period of time, undermining the quality and systematic implementation of activities. PRIME had no control over those factors nor had its own financial resources to carry the planned activities in the desired manner.

9. **Future Directions:** *What should be done better in the future regarding the performance of the primary provider? In a possible follow-on global cooperative agreement or contract what would you like to see that better supports Mission needs? What was missing under the existing arrangement? What could have been forgone?*

In future interventions to improve performance of primary providers, I think more emphasis should be given to identify all the factors that influence performance, prioritize the factors, and address them as needed through appropriate interventions. I also want to point out that we have done almost nothing to develop a realistic incentives and recognition system to link with better performance. This is critical and needs to be

addressed in future performance improvement interventions. Training is important and the quality of training has to be ensured at every stage. But training alone is not going to improve performance if we ignore other organizational factors.

10. Additional Comments: *Please add any further comments you'd like to make regarding PRIME II's work in your country…past, present, and future.*

None.

BENIN

1. **Implementation Results:** *Were the PRIME II interventions in your country useful in improving the effectiveness of targeted service providers? Please explain. If there is as yet no objective measure of this, please provide your best judgment as to whether the interventions have or will improve service delivery outcomes*.

PRIME II interventions in Benin are useful and much appreciated in improving the effectiveness of targeted service providers. For example, PRIME II has helped the MOH to strengthen its training capacity and capability and expand the FP/RH/emergency obstetric and neonatal care service delivery network of primary providers. To ensure the sustainability of training interventions, PRIME II support has worked with the MOH to ensure that the health system is equipped with trainers at all levels and national standards and training curricula adopted by the MOH and used by USAID–funded partners as well as other partner agencies.

2. **Scale and Importance:** *Have the PRIME II interventions been replicated at the regional and/or national level? If PRIME activities were scaled-up, what has been your experience with scale-up?*

Yes, the PRIME II interventions have been replicated at the regional and/or national level. For example, due to the current success of the Emergency Obstetric and Neonatal Care project, the MOH has decided to scale up and replicate efforts and other donors (UNFPA, WHO) are using the program as a model for their activities.

3. **Strategic Fit:** *Were the PRIME II interventions in your country specifically designed and tailored to support the Mission strategy? The government strategy?*

PRIME II has contributed to the achievement of USAID/Benin Strategic Objective 2 (SO 2), increased use of family health services and preventive measures within a supportive policy environment. PRIME II contributed results specifically to IR 1 (improved policy environment), IR 2 (improved access), and IR 3 (improved quality).

4. **Management of Resources:** *How has PRIME II managed its personnel and resources in your country?*

PRIME II managed its personnel and resources according to PRIME and USAID regulations.

5. **Technical Approach and Style:** *Please comment on PRIME II's technical proficiency, timeliness, and cultural appropriateness.*

PRIME II uses a systematic participative approach to analyze the performance of primary health care providers, identify obstacles to good performance, and design and implement interventions to address them within an environment of health sector reform. PRIME's style is based on research of partners' consensus. Its interventions take into account Ministry of Health priorities.

6. **Collaboration with Partners:** *How well did PRIME II coordinate with its consortium partners in providing needed assistance? How well did PRIME II collaborate with in-country CAs/organizations and local government institutions?*

In Benin, PRIME II has developed a number of partnerships with USAID–supported agencies and other development partners. Through these partnerships, PRIME II supports USAID/Benin's overall family health program, offering technical assistance directly to the MOH and supporting other collaborating agencies, including URC/PROSAF, PSI, Africare, and CARE.

7. **Positive Outcomes:** *What were the positive outcomes of PRIME II's work in your country?*

Some positive outcomes of PRIME II are the following: in Benin, PRIME II successfully applied the performance improvement approach to improve the performance of service providers in caring for obstetric and neonatal emergencies in the Malanville-Karimama health zone. After the successful performance improvement experience in this health zone, USAID's bilateral project, PROSAF, adapted the approach and intervention plan for use in two other health zones in the same department (Banikoara and Sinende-Bembereke).

In Benin, PRIME II worked with the MOH to develop, test, and apply a strategy to ensure efficient application of the family health service policy, norms, and standards by the service providers. This strategy involved the combination of three training approaches (classic, tutoring, and self-directed training). The strategy was tested in the departments of Borgou/Alibori, Atlantic/Littoral, and Mono/Couffo. The MOH will use this training strategy for nationwide dissemination of family health service protocols.

8. **Challenges and Constraints:** *What didn't work out so well? Why?*

Some challenges are

- extension of pilot experience of EONC, preventing postpartum hemorrhage, and postabortion care;
- sustainability of PRIME II activities; and
- family health norms and protocols dissemination.

Some constraints are

- lack of personnel,
- lack of transportation means, and
- lack of funds.

9. **Future Directions:** *What should be done better in the future regarding the performance of the primary provider? In a possible follow-on global cooperative agreement or contract what would you like to see that better supports Mission needs? What was missing under the existing arrangement? What could have been forgone?*

PRIME should extend its interventions to an important number of health providers; help the MOH in defining performance improvement policy.

10. **Additional Comments:** *Please add any further comments you'd like to make regarding PRIME II's work in your country…past, present, and future.*

It should be necessary to extend PRIME.

Thank you most sincerely for your responses and insights.

DOMINICAN REPUBLIC

1. **Implementation Results:** *Were the PRIME II interventions in your country useful in improving the effectiveness of targeted service providers? Please explain. If there is as yet no objective measure of this, please provide your best judgment as to whether the interventions have or will improve service delivery outcomes.*

Yes, PRIME II interventions, such as the community COPE and research on improved training techniques for health care providers, were very useful. If lessons learned there from could be applied to actual service delivery, it would certainly improve the outcomes. The issue is how far is the government or other private partners willing to incorporate these instruments.

2. **Scale and Importance:** *Have the PRIME II interventions been replicated at the regional and/or national level? If PRIME activities were scaled-up, what has been your experience with scale-up?*

Unfortunately, the Mission in the Dominican Republic did not contemplate extended funding for PRIME II under the new strategy, therefore the issue of scaling up activities might not be feasible.

3. **Strategic Fit:** *Were the PRIME II interventions in your country specifically designed and tailored to support the Mission strategy? The government strategy?*

Yes, PRIME II interventions were very supportive of the Mission RH strategy, and in a way shaped up the government strategy.

4. **Management of Resources:** *How has PRIME II managed its personnel and resources in your country?*

Being that the PRIME II office in the Dominican Republic is a regional office, in quite a number of instances the regional commitments, in terms of use of personnel, took precedence over the country needs.

5. **Timeliness, Technical Approach, and Style:** *Please comment on PRIME II's technical proficiency, timeliness, and cultural appropriateness.*

Where PRIME II excelled in the Dominican Republic was in the cultural appropriateness of its interventions, due particularly to the excellent local professional staff on site.

6. **Collaboration with Partners:** *How well did PRIME II coordinate with its consortium partners in providing needed assistance? How well did PRIME II collaborate with in-country CAs/organizations and local government institutions?*

Coordination with its consortium partners, such as EngenderHealth, was optimum. Both engaged in joint activities in a very coordinated manner. Also, the relationship with local government institutions was very good.

7. **Positive Outcomes:** *What were the most positive outcomes of PRIME II's work in your country?*

Training of providers on quality of care issues introducing innovative instruments, such as the clinic and community COPE. One public health care service targeted was the Bayaguana hospital, where the Mission will have to see if these made a real impact.

8. **Challenges and Constraints:** *What didn't work out so well? Why?*

Technical assistance was sort of intermittent due to other commitments of PRIME II staff, mostly outside the country.

9. **Future Directions:** *What should be done better in the future regarding the performance of the primary provider? In a possible follow-on global cooperative agreement or contract what would you like to see that better supports Mission needs? What was missing under the existing arrangement? What could have been foregone?*

[No comment]

10. **Additional Comments:** *Please add any further comments you'd like to make regarding PRIME II's work in your country…past, present, or future.*

[No comment]

Thank you most sincerely for your responses and insights.

EL SALVADOR

1. **Implementation Results:** *Were the PRIME II interventions in your country useful in improving the effectiveness of targeted service providers? Please explain. If there is as yet no objective measure of this, please provide your best judgment as to whether the interventions have or will improve service delivery outcomes.*

Interventions carried out by PRIME II in El Salvador are very useful and much valued. Such interventions have provided a key contribution to the improvements of reproductive health in-country by upgrading the effectiveness and quality of services provided by health care providers. With PRIME II assistance, the MOH has developed a cradle of "champions" in reproductive health nationwide. These teams are sharing their experiences, knowledge, and skills in reproductive health with other health personnel, ensuring that the MOH is prepared with trainers at all levels, national standards, and several training curricula in reproductive health issues.

2. **Scale and Importance:** *Have the PRIME II interventions been replicated at the regional and/or national level? If PRIME activities were scaled-up, what has been your experience with scale-up?*

Yes, PRIME II started activities in some geographic areas in El Salvador. Due to its success, interventions have been replicated in other regions and some at the national level. This is the case, for example, with the Adolescents Reproductive Health Activities, which started in three departments and now are being replicated in another seven, and also other donors are using the program as a model for their activities.

3. **Strategic Fit:** *Were the PRIME II interventions in your country specifically designed and tailored to support the Mission strategy? The government strategy?*

PRIME II interventions were designed at the beginning of USAID's current strategic period. Interventions and strategies were planned in collaboration with USAID and MOH staff. Thus, PRIME II activities contribute to the achievement of USAID/El Salvador health Strategic Objectives by improving access and use of reproductive health practices and service. PRIME II project heavily contributes to the MOH's goals of reducing maternal mortality in the country, which is one of its main objectives. PRIME II has also proven to be very flexible in addressing USAID and MOH changing needs and focus.

4. **Management of Resources:** *How has PRIME II managed its personnel and resources in your country?*

PRIME II managed its personnel fairly. However, more attention should be put into addressing personnel benefits to comply with local laws. Resources are managed well and according to USAID regulations.

5. **Technical Approach and Style:** *Please comment on PRIME II's technical proficiency, timeliness, and cultural appropriateness.*

The participative and results-oriented approach utilized by the PRIME II program allowed the MOH to undertake interventions to apply culturally sound practices and methodologies. PRIME II staff in El Salvador is very effective, with high levels of responsiveness.

6. **Collaboration with Partners:** *How well did PRIME II coordinate with its consortium partners in providing needed assistance? How well did PRIME II collaborate with in-country CAs/organizations and local government institutions?*

PRIME II has demonstrated good collaboration and coordination with other CAs, such as JSI (in the case of contraceptives management) and FHI (in the case of FP norms). PRIME II has also contributed (with USAID) in its good working and collaborative relationship with stakeholders and other donors in the reproductive health sector, such as GTZ, UNFPA, UNICEF, and PAHO.

7. **Positive Outcomes:** *What were the positive outcomes of PRIME II's work in your country?*

Some positive outcomes are the development of training curricula and information, education, and communication materials in several reproductive health areas (emergency obstetric care, adolescent reproductive health, improvement of quality of care, postpartum care); providers applying newly developed norms and protocols, training of trainer teams developed in all health regions; adolescent-friendly services in eight health regions; COPE and facilitated supervisions applied in a great number of health facilities for the improvement of quality of care; the development and implementation of a new logistics system for the distribution and information of contraceptives nationwide; the development and successful implementation of a nationwide community-based program for family planning; the development of a continued education program for traditional midwives; postpartum and postabortion care services launched in seven hospitals; and the development and implementation of an emergency obstetric care program to reduce maternal mortality at the community level.

8. **Challenges and Constraints:** *What didn't work out so well? Why?*

Some challenges are

- sustainability and expansion of PRIME II activities;
- transfer of monitoring responsibilities, tools, and skills to MOH personnel; and
- PRIME II legal status in El Salvador and the tax reimbursement process.

9. **Future Directions:** *What should be done better in the future regarding the performance of the primary provider? In a possible follow-on global cooperative agreement or contract what would you like to see that better supports Mission needs? What was missing under the existing arrangement? What could have been forgone?*

PRIME should

- define and provide more support to local country offices in their legal status, regulations training, and compliance;
- transfer its worldwide lessons learned to local offices, for example, being more flexible in performance improvement approaches; not only use training as a method to improve performance; and
- consider better ways to integrate child health care activities into reproductive health interventions; needs are always great and resources are limited.

10. **Additional Comments:** *Please add any further comments you'd like to make regarding PRIME II's work in your country…past, present, or future.*

[No comment]

Thank you most sincerely for your responses and insights.

KENYA

1. **Implementation Results:** *Were the PRIME II interventions in your country useful in improving the effectiveness of targeted service providers? Please explain. If there is as yet no objective measure of this, please provide your best judgment as to whether the interventions have or will improve service delivery outcomes.*

PRIME II interventions were useful and the targeted providers are able to provide PAC services with ease. The service providers have gone further and formed clusters in which they can assist and update one another.

2. **Scale and Importance:** *Have the PRIME II interventions been replicated at the regional and/or national level? If PRIME activities were scaled-up, what has been your experience with scale-up?*

PRIME II interventions have been scaled up. At first the interventions were carried out in three provinces and now have been extended to another province. In the current scale up, another cadre of providers (clinical officers) has been included. This is due to demand.

3. **Strategic Fit:** *Were the PRIME II interventions in your country specifically designed and tailored to support the Mission strategy? The government strategy?*

PRIME II interventions were specifically designed to complement the Mission's and government's effort in addressing safe motherhood.

4. **Management of Resources:** *How has PRIME II managed its personnel and resources in your country?*

PRIME II has managed its personnel and resources in a professional manner.

5. **Timeliness, Technical Approach, and Style:** *Please comment on PRIME II's technical proficiency, timeliness and cultural appropriateness.*

PRIME II staff gets things done on time in a proficient manner and is sensitive to cultural beliefs especially now that it is in an area that is dominated by Muslim faith. PRIME has been able to incorporate them.

6. **Collaboration With Partners:** *How well did PRIME II coordinate with its consortium partners in providing needed assistance? How well did PRIME II collaborate with in-country CAs/organizations and local government institutions?*

PRIME II coordinated very well with its consortium partners and this was evident in its partners taking up their role when required. Have witnessed this in the area of cost analysis training taken up by EngenderHealth. PRIME II was and still is a member of the PAC Working Group and during training, government facilities are used for practicum.

7. **Positive Outcomes:** *What were the most positive outcomes of PRIME II's work in your country?*

The most positive outcomes are in the area of working with the government, other CAs, and the nurses' association and to prove that PAC can be performed by a lower cadre than doctors in a professional way.

8. **Challenges and Constraints:** *What didn't work out so well? Why?*

The most challenging was the issue of manual vacuum aspiration (MVA) kits. There was a delay in getting the kits to the providers. This has been sorted as of now.

9. **Future Directions:** *What should be done better in the future regarding the performance of the primary provider? In a possible follow-on global cooperative agreement or contract what would you like to see that better supports Mission needs? What was missing under the existing arrangement? What could have been foregone?*

The Mission and/or government should negotiate on how to get the MVA kits to avoid a gap between when providers are trained and when they start providing services. Counseling on issues of HIV/AIDS should be integrated in future programs.

10. **Additional Comments:** *Please add any further comments you'd like to make regarding PRIME II's work in your country…past, present, or future.*

PRIME II has been very responsive to the Mission's needs and is doing a very good job, which is appreciated and supported by the host government.

Thank you most sincerely for your responses and insights.

KYRGYZSTAN

1. **Implementation Results:** *Were the PRIME II interventions in your country useful in improving the effectiveness of targeted service providers? Please explain. If there is as yet no objective measure of this, please provide your best judgment as to whether the interventions have or will improve service delivery outcomes.*

The first activity is to develop and test an approach for increasing the accessibility and use of postabortion family planning services in Osh and Jalalabad in Kyrgyzstan. Data have been selected that will identify client, provider, and facility-level variables that may influence the accessibility and use of postabortion family planning services. Six focus groups are being conducted.

The second activity, which has not yet been initiated, is to conduct a provider performance motivation study. It will seek to evaluate the effectiveness of public posting on provider performance among public sector primary health care providers in family planning and reproductive health clinics.

The first activity has the potential to improve service delivery outcomes but its sustainability may be questionable. Unable to estimate potential success of the second activity.

2. **Scale and Importance:** *Have the PRIME II interventions been replicated at the regional and/or national level? If PRIME activities were scaled-up, what has been your experience with scale-up?*

Not applicable.

3. **Strategic Fit:** *Were the PRIME II interventions in your country specifically designed and tailored to support the Mission strategy?*

No, but when proposed, the intervention appeared to be most complementary to other Kyrgyzstan health activities.

The government strategy?

No.

4. **Management of Resources:** *How has PRIME II managed its personnel and resources in your country?*

Effectively.

5. **Timeliness, Technical Approach, and Style:** *Please comment on PRIME II's technical proficiency, timeliness, and cultural appropriateness.*

The results of the baseline assessment have not been released so it is difficult to comment on technical proficiency. The first activity seems to be well planned and organized. Unable to comment on cultural appropriateness at this time.

6. **Collaboration with Partners:** *How well did PRIME II coordinate with its consortium partners in providing needed assistance? How well did PRIME II collaborate with in-country CAs/organizations and local government institutions?*

Unknown.

The first stakeholders' meeting is being conducted in Osh this week in relation to postabortion services. Since PRIME was able to gain access to local Kyrgyzstan institutions with little assistance from USAID, one could conclude that PRIME has been able to collaborate effectively with local government institutions in these initial steps.

7. **Positive Outcomes:** *What were the positive outcomes of PRIME II's work in your country?*

Still in early implementation. Baseline analysis of first activity still not complete. Second activity not yet started.

8. **Challenges and Constraints:** *What didn't work out so well? Why?*

Not applicable.

9. **Future Directions:** *What should be done better in the future regarding the performance of the primary provider? In a possible follow-on global CA or contract what would you like to see that better supports Mission needs? What was missing under the existing arrangement? What could have been forgone?*

Too early to comment.

10. **Additional Comments:** *Please add any further comments you'd like to make regarding PRIME II's work in your country…past, present, and future.*

[No comment]

Thank you most sincerely for your responses and insights.

MALI

1. **Implementation Results:** *Were the PRIME II interventions in your country useful in improving the effectiveness of targeted service providers? Please explain. If there is as yet no objective measure of this, please provide your best judgment as to whether the interventions have or will improve service delivery outcomes.*

There is no objective judgment for this; however, one can say that PRIME II intervention in preservice training for future reproductive health services providers as well as various approaches being implemented for inservice training are likely to improve service delivery outcomes. A systematic evaluation methodology will need to be applied for an objective assessment of the outcomes.

2. **Scale and Importance:** *Have the PRIME II interventions been replicated at the regional and/or national level? If PRIME activities were scaled-up, what has been your experience with scale-up?*

The strategy designed by PRIME II for inservice training has been disseminated nationwide and is being followed by all the regions.

3. **Strategic Fit:** *Were the PRIME II interventions in your country specifically designed and tailored to support the Mission strategy?*

Overall, YES; however, some specific interventions, such as postabortion care and female genital cutting, though they address well national health problems, were not part of the ending Mission strategy.

The government strategy? YES!

4. **Management of Resources:** *How has PRIME II managed its personnel and resources in your country?*

A small team of Malian nationals was in charge of interventions and the team received technical assistance from the INTRAH PRIME teams in Dakar and Chapel Hill.

5. **Timeliness, Technical Approach, and Style:** *Please comment on PRIME II's technical proficiency, timeliness, and cultural appropriateness.*

Not enough elements to comment on this; however, in May 2002, the Mission health team leader was obliged to remind PRIME II to be more proactive so that the Mission and the MOH can feel their presence.

6. **Collaboration with Partners:** *How well did PRIME II coordinate with its consortium partners in providing needed assistance? How well did PRIME II collaborate with in-country CAs/organizations and local government institutions?*

No elements to comment on coordination of the consortium.

Regarding local government institutions, in the end, the PRIME II team was able to engage the MOH training unit and the MOH reproductive health division behind the interventions. The collaboration with the MOH was good.

7. **Positive Outcomes:** *What were the most positive outcomes of PRIME II's work in your country?*

The inservice training strategy and alternative approaches to performance improvement through nontraditional classroom training.

8. **Challenges and Constraints:** *What didn't work out so well? Why?*

Preservice training, though promising, has not been designed and implemented smoothly; there are administrative conditions to be established by the national education authorities for preservice training curricula to fully integrate and teach materials designed under PRIME II intervention.

9. **Future Directions:** *What should be done better in the future regarding the performance of the primary provider? In a possible follow-on global cooperative agreement or contract what would you like to see that better supports Mission needs? What was missing under the existing arrangement? What could have been foregone?*

A more comprehensive and global vision of capacity reinforcement, skills development, and performance improvement of service providers during preservice training and inservice training will be needed.

New ways of designing and adapting alternative approaches to traditional classroom training for inservice must continue.

Looking at the service provider beyond the health facility walls must be part of the new thinking for future interventions.

10. **Additional Comments:** *Please add any further comments you'd like to make regarding PRIME II's work in your country…past, present, or future.*

[No comment]

Thank you most sincerely for your responses and insights.

NICARAGUA

1. **Implementation Results:** *Were the PRIME II interventions in your country useful in improving the effectiveness of targeted service providers? Please explain. If there is as yet no objective measure of this, please provide your best judgment as to whether the interventions have or will improve service delivery outcomes.*

Through the Emergency Obstetric and Neonatal Care Project, PRIME trained 51 parteras and 109 physicians, nurses, and auxiliary nurses, 85 from the Ministry of Health and 24 from private voluntary organizations (PVOs) in community-based life-saving skills for managing and preventing obstetric emergencies.

The final evaluation of the program demonstrates significant improvement in provider performance. As defined by a quality index score, care of immediate postpartum women by traditional birth attendants has improved 87 percent. Management of postpartum hemorrhaging by physicians, nurses, and auxiliary nurses has risen 20 percent. Feedback from the Ministry of Health has been quite positive.

Through the PRIME II/PATH project with IXCHEN, staff from 64 pharmacies received skills updates in emergency contraception and were trained in consumer perspective and interpersonal communication techniques to improve relations between pharmacists and youth in three periurban areas of Managua. Pharmacists were trained to use tools to inquire what each young client needs so as to redesign pharmacy services to meet those needs.

2. **Scale and Importance:** *Have the PRIME II interventions been replicated at the regional and/or national level? If PRIME activities were scaled-up, what has been your experience with scale-up?*

As a result of its experience in Jinotega, PRIME II participated closely on the National MOH Commission to develop emergency obstetric and neonatal care protocols. The protocols are evidence-based validation from the national referral hospital, regional and departmental hospitals, and health centers. A practical document to enable health personnel to apply and follow the protocols on a nationwide basis should be ready by the end of 2003.

PRIME's activities have been picked up by the NicaSalud Federation of PVOs and NGOs, and have been absorbed into its multiyear work plan. PRIME II's field coordinator has been absorbed into the NicaSalud technical staff. This supports replication and scale-up on a national level.

3. **Strategic Fit:** *Were the PRIME II interventions in your country specifically designed and tailored to support the Mission strategy? The government strategy?*

Yes, PRIME II interventions were shaped to meet with our strategy and governmental priorities.

4. **Management of Resources:** *How has PRIME II managed its personnel and resources in your country?*

Adequate and consistent with the country plan.

5. **Timeliness, Technical Approach, and Style:** *Please comment on PRIME II's technical proficiency, timeliness, and cultural appropriateness.*

Adequate and consistent with the country plan.

Emergency Obstetric and Neonatal Training: The training for service providers from health establishments and parteras was adapted from an approach used by the American College of Nurse-Midwives to incorporate the particular needs and context of the Jinotega realities and context. The training design was evidence based and incorporated both theory and practice for performance-based learning for adults. Partera training was specifically targeted to their literacy and experience level, and they received pictorial job aids to assist them in incorporating their new learning back in their communities.

Emergency Contraception Training: The methodology for training adolescent peer promoters was designed to address their particular learning needs and preferences. Through focused training, pharmacists were made sensitive to the special needs of adolescents and learned techniques of interacting with adolescents via case studies and practice.

6. **Collaboration with Partners:** *How well did PRIME II coordinate with its consortium partners in providing needed assistance? How well did PRIME II collaborate with in-country CAs/organizations and local government institutions?*

See above, also one can note that PRIME II's project success was due in large part to the effective partnership it formed with NicaSalud, Project Hope, Project Concern International, Wisconsin Partners of the Americas, and Catholic Relief Services. This consortium of organizations was instrumental in working with SILAIS/Jinotega and its respective health establishments to develop, implement, and monitor the project activities and interventions.

A qualitative evaluation to assess the integration of the different partners in the consortium to implement the Emergency Obstetric Neonatal Care project showed that the strengths of the partnership were many with the different organizations sharing resources, time, funds, and objectives to conduct a successful project. Those interviewed agreed that the "biggest strength was demonstrating to themselves and the MOH that united they are more credible and solid to develop and implement a strategy of various components at the institutional level as well as in the community." Working as a consortium provided the opportunity to demonstrate to the MOH a project with local leadership capacity, solidarity among organizations, and technical capacity to manage the processes.

7. **Positive Outcomes:** *What were the most positive outcomes of PRIME II's work in your country?*

Obtaining Ministry of Health buy-in for the initiatives.

8. Challenges and Constraints: *What didn't work out so well? Why?*

PRIME II had hoped for greater and earlier buy-in from the initial group of partner PVOs. While efforts were made to promote consensus at the country director level, this did not lead to measurably better coordination with a number of the organizations. This situation began to improve as the PRIME effort was brought more closely under the wing of the current technical assistance mechanism available to PVOs through NicaSalud.

9. Future Directions: *What should be done better in the future regarding the performance of the primary provider? In a possible follow-on global cooperative agreement or contract what would you like to see that better supports Mission needs? What was missing under the existing arrangement? What could have been foregone?*

I'm hoping that services available under PRIME from PRIME partners will be accessible under the TASC II IQC. Given the direction of the regional Central America and Mexico strategy, the need to bundle procurements and work orders into the fewest management units is a major concern.

10. Additional Comments: *Please add any further comments you'd like to make regarding PRIME II's work in your country…past, present, or future.*

[No comment]

Thank you most sincerely for your responses and insights.

RWANDA

1. **Implementation Results**: *Were the PRIME II interventions in your country useful in improving the effectiveness of targeted service providers? Please explain. If there is as yet no objective measure of this, please provide your best judgment as to whether the interventions have or will improve service delivery outcomes.*

PRIME II has a vast portfolio of activities in Rwanda. In every domain, from community participation in quality to prevention of mother-to-child transmission (PMTCT) service delivery to community health insurance policy and program development, and everything in between, PRIME II has achieved significant results. Although it is still too early to measure the impact on the overall quality of services resulting from all the training that PRIME II has implemented in its focus areas (FP, safe motherhood, etc.), it is quite clear that it has paved the way for creating a very favorable environment for improved quality. Support for facilitative supervision, community participation, increased financial access to care, along with the comprehensive training strategy, will no doubt lead to an overall improvement in increased use of health care, which is USAID/Rwanda's Strategic Objective.

2. **Scale and Importance:** *Have the PRIME II interventions been replicated at the regional and/or national level? If PRIME activities were scaled-up, what has been your experience with scale-up?*

Many of PRIME II's interventions have been scaled up or replicated for use by other partners. For example, the community participation in quality (PAQ) approach has been very successful in one of the regions (Byumba) where the medical director requested that PRIME scale up to cover the full region even before the first assessment had been completed on the few pilot sites. Another example is the partner invitation letter that PRIME II developed within the context of its PMTCT activities to encourage partners to accompany the women in the antenatal care counseling and testing sessions. The model has been adopted by other partners and will be included in the National PMTCT Training Module currently under development. Finally, the family planning materials developed by PRIME (national logo, provider flip chart, and client brochures for each method) are national materials that will be used across the country in the Global Fund voluntary counseling and testing (VCT)/PMTCT sites and by UNFPA in its activities.

3. **Strategic Fit:** *Were the PRIME II interventions in your country specifically designed and tailored to support the Mission strategy? The government strategy?*

PRIME II's activities were tailored from the beginning to reflect the Mission's strategy and to respond to specific interests of the Mission. Over the past two years, PRIME's activities have become more internally coherent and comprehensive thanks to the efforts of the PRIME's country team. This has been of value to both the Mission and the government of Rwanda since PRIME II has directly supported the development of two national strategies (reproductive health and community health insurance).

4. **Management of Resources:** *How has PRIME II managed its personnel and resources in your country?*

PRIME II has received significant resources from USAID/Rwanda and the Mission is very satisfied with the management and use of those resources. Although there have been personnel challenges in the PRIME II country office, all the issues have been resolved in a constructive manner. The PRIME II country office maintains high standards and a good team spirit.

5. **Timeliness, Technical Approach, and Style:** *Please comment on PRIME II's technical proficiency, timeliness, and cultural appropriateness.*

On all three points, PRIME II receives stellar marks. PRIME II always responds in a timely fashion to USAID/Rwanda requests and initiatives. PRIME II's technical approach is appreciated by all partners operating in Rwanda, particularly in that it brings a unique perspective concerning community participation and gender sensitization. Finally, PRIME II's technical staff is very aware and respectful of the cultural realities influencing health service delivery, health-seeking behavior, and international technical assistance. There has never been an incident to suggest that any of PRIME's staff or its policy is in conflict with the local realities.

6. **Collaboration with Partners:** *How well did PRIME II coordinate with its consortium partners in providing needed assistance? How well did PRIME II collaborate with in-country CAs/organizations and local government institutions?*

USAID/Rwanda has been primarily aware of Abt as the most active consortium partner working in Rwanda under PRIME. The coordination of Abt's contribution in Rwanda has greatly improved over time, to the point that Abt's involvement is critical for community health insurance activities. PRIME II collaborated relatively well with the government of Rwanda, MOH. Relationships were constructive on most levels, but there has always been a degree of competition between what PRIME is implementing and what the MOH is implementing. Again, PRIME has come to terms with this challenge and has recognized that it is there to support the MOH's implementation of the activities. This is equally true of PRIME II's collaboration with other CAs. PRIME has come to terms with the fact that it needs to work together to complement each other and share information.

7. **Challenges and Constraints:** *What were the most positive outcomes of PRIME II's work in your country?*

One activity that has not been as successful as hoped is PRIME's support for the revision of the national nursing curriculum to update the reproductive health modules. Working across ministries (i.e., the MOH and Ministry of Education) has proven quite difficult and perhaps beyond the reach of PRIME's scope at this time.

8. **Future Directions:** *What didn't work out so well? Why?*

If PRIME II continues to include HIV/AIDS activities, such as PMTCT, then its agreement has to permit procurement of test kits, drugs, etc., which are essential for effective HIV/AIDS activities. In addition, USAID/Rwanda understands that PRIME II

is limited in its ability to use subagreements with local partners as a mechanism for directly supporting activities at service delivery sites and community organizations. This has impeded its level of flexibility to respond to opportunities in a timely and constructive manner.

9. **Future Directions:** *What should be done better in the future regarding the performance of the primary provider? In a possible follow-on global cooperative agreement or contract what would you like to see that better supports Mission needs? What was missing under the existing arrangement? What could have been foregone?*

[No comment]

10. **Additional Comments:** *Please add any further comments you'd like to make regarding PRIME II's work in your country…past, present, or future.*

[No comment]

Thank you most sincerely for your responses and insights.

TANZANIA

1. **Implementation Results:** *Were the PRIME II interventions in your country useful in improving the effectiveness of targeted service providers? Please explain. If there is as yet no objective measure of this, please provide your best judgment as to whether the interventions have or will improve service delivery outcomes.*

The following are the implementation results of the PRIME II program in Tanzania:

- **PRIME II Intermediate Results**

  - PRIME II provided technical assistance to the Reproductive and Child Health section of the MOH to design and develop eight trainer guides and eight trainee manuals and job aids. These documents have been designed to be used for preservice and inservice training programs as well as on the job training in order to improve the quality of family planning services and provider performance. In order to maximize the results and ensure proper use of these documents, PRIME II will work with the Reproductive and Child Health section and the zonal training centers to disseminate these documents and monitor service providers' adherence to FP service standards.

  - USAID/Tanzania requested that PRIME II assist in building the capacity of the two zonal training centers to enable them to assist districts in managing better the health programs in the decentralized system within the health sector reforms. The districts are expected to improve the quality of health care and provide the needed support to the service providers to improve performance. As a result, 20 zonal training center staff members have been trained in costing, pricing, marketing, and alternate training. Zonal training centers will in turn roll it out to the districts.

  - PRIME II provided technical assistance to the Reproductive and Child Health section of the MOH to develop, design, and facilitate printing the comprehensive PAC clinical skills training curriculum, performance service standards, trainees manual, and job aids. All these documents have been used by the MOH to train 18 trainers and 50 service providers. This is an ongoing activity.

- **PRIME II Technical Leadership Areas**

  - Five staff members were trained from the Reproductive and Child Health section in the performance improvement approach.

  - Performance needs assessments were conducted for six zonal training centers. The results of the assessment were used by USAID/Tanzania and the MOH in deciding which centers should be supported in order to roll out the Quality Improvement Initiative in Tanzania.

- PRIME II oriented council health management teams in three districts in the performance improvement approach. It assisted the districts to adapt data collection tools, conduct the pilot, revise the tool, and develop data collection plans. The council health management team conducted the assessment and PRIME II assisted them with data analysis and report writing. The planned interventions will be followed up by PRIME II during FY 2003–04.

- Twenty-seven staff from three regions were trained in quality improvement and the performance improvement approach.

▪ **HIV/AIDS Integration with Family Planning**

- PRIME II focuses on standardizing and implementing approaches to integrate HIV/AIDS into the ongoing FP/RH programs. All the documents that were developed for FP have content on the prevention of HIV/AIDS.

2. **Scale and Importance:** *Have the PRIME II interventions been replicated at the regional and/or national level? If PRIME activities were scaled-up, what has been your experience with scale-up?*

PRIME II activities have not been scaled up but have been limited to the central MOH (Reproductive and Child Health Section), the two zonal training centers, and three regions with 16 districts of Tanzania mainland.

3. **Strategic Fit:** *Were the PRIME II interventions in your country specifically designed and tailored to support the Mission strategy? The government strategy?*

Yes! The interventions are designed to support the implementation of the Mission strategy and the government of Tanzania health sector strategy, particularly with improving the quality of health care, which is the nucleus of the health sector reforms in Tanzania. The standards and guidelines that PRIME II assisted the MOH to design and develop will be used by all the regions and districts in Tanzania.

4. **Management of Resources:** *How has PRIME II managed its personnel and resources in your country?*

Normally PRIME II has limited manpower in its regional office in Nairobi and it hires people on a consultancy basis depending on the type of work to be done. On most of the occasions when we have requested technical assistance, we received the right people.

5. **Timeliness, Technical Approach, and Style:** *Please comment on PRIME II's technical proficiency, timeliness, and cultural appropriateness.*

PRIME II's technical comparative advantage is in training for reproductive and child health. We have also utilized PRIME II services in facilitation and team-building exercises for different groups in the MOH through its collaboration with TRG. We have not had any complaints from the local authorities about the cultural unsoundness of either the technical assistance or the people who provide it. What needs to be improved is the

use of local consultants and more effort to promote the locals in facilitation and team-building skills. PRIME II works in the same areas with other cooperative agencies almost dealing with the same technical issues. USAID/Tanzania will provide a better mechanism for the use of technical assistance in the near future. PRIME II has no office in Tanzania but it operates from its regional office in Nairobi, Kenya.

6. **Collaboration with Partners:** *How well did PRIME II coordinate with its consortium partners in providing needed assistance? How well did PRIME II collaborate with in-country CAs/organizations and local government institutions?*

PRIME II collaborated with its consortium (EngenderHealth and Intrah International) and JHPIEGO in developing and implementing postabortion care in Tanzania. Locally, PRIME II collaborated with the National Family Planning Association, the MOH, zonal training centers, and regional and district authorities. PRIME II's relationship with all of the above-mentioned collaborators is good. There is already dialogue going on between the MOH and USAID/Tanzania to allow CAs to have more in-country presence and PRIME II will benefit if they could open an office locally and build a closer partnership with the local collaborators, especially the regional and district authorities where decentralization and actual assistance is needed to improve the quality of health care.

7. **Positive Outcomes:** *What were the most positive outcomes of PRIME II's work in your country?*

   - In developing the family planning service standards and guidelines,
   - in providing assistance for institutional capacity building for the zonal training centers, and
   - in developing and institutionalizing postabortion care.

8. **Challenges and Constraints:** *What didn't work out so well? Why?*

   - Given the situation we are in, especially with the ongoing transition time to institutionalize the reforms at the district level, PRIME II's capacity could not be fully utilized because the districts and the whole system were not ready to absorb the available technical assistance from PRIME II. USAID/Tanzania will need to provide clearer guidance and expand the scope of areas where PRIME II will be operating in the future. The Mission is in the process of developing a new country strategic plan and roles of the CAs will be revised.
   - PRIME II still has a challenge in integrating HIV/AIDS in its programs. For example, while HIV/AIDS is included in the documents that PRIME II helped develop, they should also develop guidance on integrated counseling for HIV/AIDS and FP for health providers. In the situation of PMTCT, there is a big role for FP. The integration should be of a wider scope than what is done at this moment.

9. **Future Directions:** *What should be done better in the future regarding the performance of the primary provider? In a possible follow-on global cooperative*

agreement or contract what would you like to see that better supports Mission needs? What was missing under the existing arrangement? What could have been foregone?

We will need to develop a better mechanism for PRIME II to work directly with the districts. It will ensure that health providers are timely reached and assisted to improve their performance. In the current mechanism it takes a long time for the actual providers to be reached.

10. Additional Comments: *Please add any further comments you'd like to make regarding PRIME II's work in your country…past, present, or future.*

None, thanks.

Thank you most sincerely for your responses and insights.

UZBEKISTAN

1. **Implementation Results:** *Were the PRIME II interventions in your country useful in improving the effectiveness of targeted service providers? Please explain. If there is as yet no objective measure of this, please provide your best judgment as to whether the interventions have or will improve service delivery outcomes.*

The PRIME II project accomplished what it finally set out to do—facilitate the development of a competency-based learning package for normal delivery for use by primary health care providers. The package is intended for use by MOH personnel in the USAID–funded Healthy Family Project in Surkhandarya and Kashkadarya as well as during independent inservice training cycles.

2. **Scale and Importance:** *Have the PRIME II interventions been replicated at the regional and/or national level? If PRIME activities were scaled-up, what has been your experience with scale-up?*

Not applicable.

3. **Strategic Fit:** *Were the PRIME II interventions in your country specifically designed and tailored to support the Mission strategy? The government strategy?*

Yes and yes.

4. **Management of Resources:** *How has PRIME II managed its personnel and resources in your country?*

Initially, the project was beset with management difficulties; its original mission—to conduct PAC training—was overtaken by events leading to USAID/CAR's Healthy Family cooperative agreement. Following a change in project management and goal, the PRIME II team worked efficiently and quickly. The Uzbek normal delivery learning package was tested and approved within the space of 6 months.

5. **Timeliness, Technical Approach, and Style:** *Please comment on PRIME II's technical proficiency, timeliness, and cultural appropriateness.*

PRIME II was technically proficient. Its reliance on MOH experts with long tenures in international health technical assistance projects ensured timeliness and cultural appropriateness.

6. **Collaboration with Partners:** *How well did PRIME II coordinate with its consortium partners in providing needed assistance? How well did PRIME II collaborate with in-country CAs/organizations and local government institutions?*

Collaboration with local government institutions, most notably the MOH, was excellent, resulting in an approved learning package. Collaboration with other USAID CAs was strained by the competition over the larger MCH project and personality disputes.

7. **Positive Outcomes:** *What were the positive outcomes of PRIME II's work in your country?*

National clinical standards for normal delivery for primary health care providers.

8. **Challenges and Constraints:** *What didn't work out so well? Why?*

Acceptance of these standards by other donors and implementers. "Not invented here."

9. **Future Directions:** *What should be done better in the future regarding the performance of the primary provider? In a possible follow-on global cooperative agreement or contract what would you like to see that better supports Mission needs? What was missing under the existing arrangement? What could have been forgone?*

Early agreement on the scope and focus of the project, with clear stakeholder expectations and roles for project follow up.

10. **Additional Comments:** *Please add any further comments you'd like to make regarding PRIME II's work in your country…past, present, or future.*

[No comment]

Thank you most sincerely for your responses and insights.

APPENDIX D

COUNTRY SUMMARIES

COUNTRY SUMMARIES

ARMENIA

Dates of Visit
September 22–27, 2003

Principal Contacts

USAID
Edna Jonas, Senior Technical Advisor
Greg Koldys, Democracy and Governance Officer
Kathleen McDonald, Director, Democracy and Social Reform Office
Nancy Nolan, Consultant
Keith Simmons, Director, USAID/Armenia

PRIME II
Karina Bagdasarova
Mikayel Grigorian
Hayk Gyuzalyan
Lilit Hovakimyan
Rebecca Kohler, Country Director
Irene Sargsyan

Host Country Institutions
Deputy Minister of Health, Primary Health Care Unit
Vanadzor Maternity Hospital, Maternal and Child Health Center, Polyclinic 4, Gargar Rural Ambulatory, Vahagni Health Center, Health Posts, and Feldsher Acoucher Post
National Institute of Health
Yerevan State Medical University, Family Health Faculty
Center for Perinatology, Obstetrics and Gynecology
National Sexually Transmitted Infections Center, Women's Rights Center

Bilateral and International Donors
Abt Associates, Inc.
PADCO, Inc.
International Relief and Development
United Armenian Fund

Summary of Findings

Demographically, Armenia is unlike most USAID–assisted countries outside the Newly Independent States region. With a population of only about 3 million and vital statistical rates closer to those of industrialized nations, Armenia is facing a set of problems quite different from those confronted by most USAID recipients.

Figure D1
Demographic Indicators

Indicator	Value	Data Unit	Year	Source
Total Population	3,326,448		2003	BUCEN–IDB 2002
Population Growth Rate	<0.01	percent	2003	BUCEN–IDB 2002
Percent Urban	70	percent	2000	World Bank/WDI 2002
Women, 15–19	177,009		2003	BUCEN–IDB 2002
Women, 15–49	933,453		2003	BUCEN–IDB 2002
Life Expectancy at Birth	66.7		2003	BUCEN–IDB 2002
Crude Birth Rate	12.6	per 1,000	2003	BUCEN–IDB 2002
Crude Death Rate	10.2	per 1,000	2003	BUCEN–IDB 2002
Number of Live Births	41,813	000s	2003	BUCEN–IDB 2002

Officials believe that first among these problems is Armenia's already small and dwindling population size, due to very low birth rates and substantial outmigration, which is exacerbated by the high number of males working abroad. Since independence in 1992, as much as 25 percent of the population may have migrated. Additionally, the 1914 genocide, while Armenians were being expelled by the Ottoman Turks, is remembered as if it occurred just yesterday. The disastrous earthquake in 1998 that killed thousands of persons in central Armenia is also fresh in the population's memory. Thus, the Armenian government's policy is essentially pronatalist: the government wishes to *increase* the number of Armenians living in the country.

Armenia's economy is growing at a respectable 8 percent annually, faster than those of neighboring states. However, many people have yet to benefit from these gains. Unemployment remains very high (fueling both temporary [for work] and permanent outmigration), and many public services are dysfunctional. This is particularly true in the health sector, where, despite a plethora of medical personnel and facilities, there is an acute shortage of basic supplies and equipment—as well as operating funds and salaries—which limits effective service delivery. Nonetheless, rooted deep in the Armenian psyche is a desire to renounce the old Soviet-era ways and adopt new approaches and methods that will help modernize the country. PRIME II has been able to tap into this desire and bring new life and hope to service delivery personnel at the most peripheral levels. Convincing evidence of this potential change was seen.

After a slow and somewhat difficult start, PRIME II assigned a new expatriate country director, who was able to bring direction and coherence to the program quite effectively. She directs an impressive staff of energetic young professionals who work with the Armenian government and other nongovernmental entities to carry out essentially three types of programs:

- work with government institutions on improving the performance of physicians and paramedical personnel working in Lori Marz (a province in northern Armenia);

- work with the Women's Rights Center on gender issues, particularly spousal abuse; and

- work with the National Sexually Transmitted Infection (STI) Center on developing national sexually transmitted disease (STD) and HIV/AIDS guidelines.

The first of these is by far the most important in terms of its potential for increased development and for revitalizing the delivery of health services throughout the country. Unfortunately, there is little evidence that either PRIME II or the USAID Mission has as yet seriously planned for scale up; the time constraint for such planning is severe.

Conclusions and Issues

Through facility visits in Yerevan and Lori Marz, interviews, reading, and unofficial contacts, the evaluation team was able to draw accurate, if somewhat disturbing, conclusions about PRIME II's work in Armenia. These are summarized as follows:

- Despite delayed startup, there is much positive activity.
- Program interventions were strategically selected and well targeted.
- PRIME II interventions were well received at all levels; praise for PRIME II's work is abundant among recipient organizations and collaborators.
- The seven self-paced learning modules were universally embraced by trainers, supervisors, and nurses.
- The provision of simple equipment with training is critical (in Lori Marz, U.S. funding was provided).
- As in other countries, PRIME II was careful to build into its activities a strong monitoring and evaluation component.
- Evidence of positive results in terms of service delivery and service utilization is already apparent.
- There are many good ideas in the field that need to be examined and built into future program(s).
- Perhaps inevitably, a few rather important persons feel left out of the decision-making process; PRIME II has tried to reach them, but needs to try harder.
- The program may be stretched too thin, especially as only one year remains and some key interventions need emphasis.
- PRIME II needs to make a strong effort at improved and especially simpler communications with key persons, including partners and USAID, to ensure that the nature and strategic importance of its interventions are clearly understood.

- Some interventions are clearly more important than others in terms of the potential for national impact on reproductive and family health.

- Especially the work in Lori Marz (performance improvement, training, self-paced learning, equipment and supplies, follow up) has tremendous potential for countrywide expansion and impact.

- Both PRIME II and USAID need to begin planning seriously for the future (after the PRIME II cooperative agreement ends).

In summary, PRIME II has accomplished much in a relatively short time in Armenia. It has engaged host country and other development partners in a range of reproductive health (RH) and related interventions, some of which already show positive results and have great potential for expansion. The interventions in Lori Marz demonstrate clearly that through the use of the performance improvement process, innovative training techniques (especially the seven self-paced modules) coupled with follow-up visits, and the provision of simple equipment and supplies, it is possible to reinvigorate the delivery of services by feldsher acoucher posts and second tier health facilities (ambulatories, health centers, polyclinics). It also appears that this work is stimulating community interest in using these health facilities, an important concern of the Armenian government. However, these gains are in jeopardy unless PRIME II and USAID determine a way to continue this work after the PRIME II project ends next year. Failure to do so would be tragic and wasteful.

BANGLADESH

Dates of Visit
September 29–October 3, 2003

Principal Contacts

USAID
Kishan Chakravorty, Population and Health Team

PRIME II
Jim McMahan, Staff from North Carolina
National Integrated Population and Health Program (NIPHP) (USAID)
Dr. Merina Adhikary
Dr. Shalini Shah
Health and Population Sector Program (HPSP) (Government of Bangladesh)
Golam Ahad, National Consultant, Performance Training
Dr. Kazi Belayet Ali, National Consultant, Performance Evaluation
Nazrul Islam, National Consultant, Training Management Information System
Dr. Aftab Uddin, Senior National Consultant, Program Management

Host Country Institutions
Health Directorate
Ministry of Health
Director General's Office
Training Technical Unit
Associates in Training and Management, Lead Training Organization, NIPHP
Radda MCH–FP Center, Lead Training Organization, NIPHP
Institute for Child and Mother Health, Lead Training Organization, NIPHP
Gano Unnayan Sangstha, HPSP
Population Services and Training Centre, NIPHP and HPSP (management support)
National Institute for Population Research and Training, HPSP

Bilateral and International Donors
USAID

Summary of Findings

In Bangladesh, with 138 million in population and 37 million women of reproductive age, the numbers in any meaningful program tend to be huge.

PRIME was engaged in two large programs in Bangladesh: the USAID–funded National Integrated Population and Health Program (NIPHP) and the government of Bangladesh's Health Population Sector Program (HPSP). The latter was funded by the World Bank and its consortium.

Figure D2
Demographic Indicators

Indicator	Value	Data Unit	Year	Source
Total Population	138,448,210		2003	BUCEN–IDB 2002
Population Growth Rate	2.1	percent	2003	BUCEN–IDB 2002
Percent Urban	24.5	percent	2000	World Bank/WDI 2002
Women, 15–19	9,068,677		2003	BUCEN–IDB 2002
Women, 15–49	37,213,170		2003	BUCEN–IDB 2002
Life Expectancy at Birth	61.3		2003	BUCEN–IDB 2002
Crude Birth Rate	29.9	per 1,000	2003	BUCEN–IDB 2002
Crude Death Rate	8.6	per 1,000	2003	BUCEN–IDB 2002
Number of Live Births	4,139,601	000s	2003	BUCEN–IDB 2002

In 1998, the government of Bangladesh embarked on an integration process for the health and family planning directorates. The goal was to provide integrated services for the upazila level and below. These services were packaged in the Essential Services Package that included reproductive health, child health, communicable disease control, limited curative care, and behavior change communication. All the services were aimed at improving the health of poor women and children. This new system required substantial changes in both management and training for the government system.

Immediately before the finalization of HPSP, NIPHP was developed. Although this program focuses on the work of nongovernmental organizations (NGOs), NIPHP reflected the government's program and service delivery thrusts and worked with its NGO partners to use the Essential Services Package as the basis of their service delivery and training programs.

PRIME was not an original partner in NIPHP but was invited to join the ongoing program in early 1998. PRIME's role was to assist the partnership in implementing the training component of the program. It was to work with the Quality Improvement Partnership (QIP) managed by EngenderHealth. However, in September 2000, PRIME was made a full partner and took over all training except clinical training, which remained with QIP. NIPHP ended in June 2002.

During the time with NIPHP, PRIME worked in three areas:

- development of training materials and curricula for child survival interventions, other reproductive health, and clinical management training;
- development of training and clinical skills for trainers from the lead training organizations; and
- strengthening the lead training organizations (10 organizations were originally involved).

PRIME trained the trainers to use a performance improvement system that included both the training and intensive follow up by the trainers to assess providers' skills and provide supportive supervision. In addition, PRIME developed a course for doctors and paramedics in three urban clinics on safe delivery for the Urban Family Health

Partnership. There was an impact on safe delivery services—clinics were delivering an average of 18 babies per month.

In a final assessment of the lead training organizations, PRIME found that most had progressed from the baseline. The final assessment showed improvement in seven essential areas: infrastructure, responsive planning, use and development of training materials, quality of training, number of courses offered and number and variety of cadres trained, use of management information systems (MIS) for training management, and application of evaluation. There is evidence that the training had an impact on service delivery improvement. The knowledge and skills of paramedics showed improvement in child survival interventions and other reproductive health. Clients also have a favorable impression of the service providers and services. Ninety-four percent indicated that there is improved counseling and that providers maintain confidentiality and advise about return visits. Further, the clients are satisfied with the waiting arrangements, clinic timings, and services.

Six of the original 10 lead training organizations are poised to continue the work started with NIPHP. They have skilled trainers, experience in curricula development, and management of training programs.

The follow-on project to NIPHP is the National Service Delivery Partnership (NSDP). PRIME II is not involved in NSDP but IntraHealth is a partner (Pathfinder International is the lead). Some of the work begun with lead training organizations in support of the providers of NGO clinics will continue through the NSDP. However, University Research Co., LLC (URC) is also a partner and has its own methods of performance improvement and training. Some compromises will have to be made in the PRIME approach in order to accommodate the ideas from URC in quality improvement.

HPSP work was a special initiative for USAID with the government of Bangladesh. PRIME was to provide technical assistance to the line director (inservice training to implement the national inservice training strategy and action plan for the Essential Services Package). This line director is in the health directorate. New job descriptions needed to be developed for health and FP workers at upazila, union, and community levels in order to deliver Essential Services Package training. More than 100,000 personnel needed to be trained; this was a monumental task.

PRIME based its work with the government on technical assistance from 1999 that had outlined a national Essential Services Package training strategy.[1] The goal of the work was "to strengthen and assist the Technical Training Unit of DGHS [Directorate General of Health Services] and the Lead Training Organizations to design, manage and implement a decentralized Essential Services Package inservice training program." The principal components of the work included

- strengthening central level management capacity (Technical Training Unit);
- standardizing inservice training planning, implementation, and follow up;

[1] McMahan, J., M. Segall, and K.B. Ali, "National In-Service Training Strategy and Action Plan for the Essential Service Package 1999–2003," Line director for inservice training, Ministry of Health and Family Welfare, Government of Bangladesh, June 1999.

- strengthening local training organization capacity;
- strengthening district and upazila capacity;
- conducting training and follow up; and
- developing monitoring and evaluation capability, including a training management information system (TMIS) (also at the district level).

To accomplish this, PRIME worked with the Ministry of Health and Family Welfare (MOHFW) (both health and family planning) as well as with the lead training organizations, district and upazila health and FP managers, USAID, and other development partners (Department for International Development, United Kingdom [DFID], Japan International Cooperation Agency [JICA], United Nations Children's Fund [UNICEF], and the German Technical Cooperation [GTZ]).

At the beginning of PRIME's work with the Technical Training Unit, there were an insufficient number of staff members to implement the strategy and they were unable to conduct most of the work required. The lead training organizations were also in need of support to improve the training environment and needed more skills in training planning, monitoring, and follow up of trainees. PRIME worked to strengthen both the Technical Training Unit and the lead training organizations. A principal intervention was to introduce the performance improvement approach and to conduct a performance needs assessment in three unions.

The Technical Training Unit is enabled to implement a high-quality national inservice training system for the Essential Services Package and to track its work through the TMIS. A district management information system (DMIS) has been set up in selected districts, and that work will continue. In addition, national inservice training standards and training guidelines were developed, disseminated, and applied to monitor and enhance training quality. Supportive supervision was introduced for frontline supervisors of field service providers. Performance improvement, supportive supervision, and DMISs were introduced in three districts. The government is now developing this in the 64 districts.

To manage this intensive program, PRIME had a staff of two expatriates and four Bangladeshi professionals. They were housed in the Technical Training Unit where they could interact frequently with their counterparts for which the unit was highly appreciative.

Unfortunately, as often happens in Bangladesh, the environment for the national health and family planning program has shifted dramatically with the change in government (October 2001). The present government has abandoned the integration of services, placing emphasis on union-level facilities rather than community clinics; all of the integration of health and family planning services has been abandoned. Consequently, most community clinics have been closed (a few are being managed by NGOs) and the Essential Services Package is not being delivered. These political decisions have halted work on the new project with the World Bank and its consortium. HPSP has been

extended until December 2003 while negotiations continue on future programming. This is a major setback for all the programs, including those that PRIME has been working on in the government sector.

Conclusions and Issues

PRIME has done an excellent job in both its NIPHP and government work, introducing such new approaches as performance improvement and performance needs assessment that have helped its counterparts to improve training and training monitoring. PRIME has also introduced the concept of supportive supervision. These methods of work have had an impact on service delivery performance in both sectors. This impact is mainly due to the strong staff and its dedication to work.

The follow-on project to NIPHP will probably continue to benefit from the approaches established. However, there is a danger that the strength of performance improvement will be diminished as other partners in NSDP introduce other quality approaches. It is very possible that a combination of approaches will be developed. This is not helpful, as the lead training organizations and other partners have learned the performance improvement approach and are eager to continue using it. The introduction of yet another performance improvement–type approach will necessitate new training and systems development—a potential and unnecessary waste of time and resources.

The government of Bangladesh's program is in jeopardy because of a significant shift away from integration. The considerable work that has been done to train workers to deliver the Essential Services Package in integrated sites will be lost as these sites (i.e., the community clinics) are closed or revert to the old system of strict demarcation of duties between health care providers and family planning workers.

In other developments, the work being conducted by the Technical Training Unit (including the TMIS) may be moved out of the health directorate to the National Institute for Population Research and Training.

It is unfortunate that this is occurring when these systems are beginning to work. There is no question that these systems need some technical assistance for sustainability and to ensure optimum use of the performance improvement approach as well as the TMIS and DMIS. This is unlikely to happen while there are major questions about the follow-on program and the funding provided by the World Bank and its consortium partners.

USAID does not intend to continue funding the government of Bangladesh's initiative. This is unfortunate, as the limited time that PRIME has had to work has produced results. These results are fragile, however, and need continued support to ensure sustainability.

GHANA

Dates Visited
September 28–October 4, 2003

Principal Contacts

USAID
Jane Wickstrom, Senior Technical Advisor, Reproductive Health/Family Planning
Juliana Pwamang, Program Specialist, Reproductive Health

PRIME II
William Sampson, Country Director
Dr. Edward Bonku, Training Specialist
Janet Tornui, Training Specialist
Isabella Rockson, Monitoring and Evaluation

Host Country Institutions
District Health Directorate
Ghana Health Services
New Abirem (Birim North Region)
Community-based Health Planning and Services (CHPS), Adausena (Birim North)
Private midwifery homes, Asesewa and Somanya (Eastern Region)

Key Persons
Dr. Ken Sagoe
Dr. Patrick Aboagye
Dr. James Akpabilie
Dr. Frank Nyonator, Ghana Health Services
Tanya C. Jones
L. Placide Tapsoba, The Population Council
A. Nignpense, EngenderHealth
Emmanuel Fiagbey, Johns Hopkins University/Center for Communication Programs (JHU/CCP)
Kathlyn Ababio
Matilda Bannerman-Wylff
Dora Komladzei-Amoyaw, Ghana Registered Midwives Association (GRMA)
Abigail Kyei, JHPIEGO
Community Health Officers
Regional Resource Team Members
GRMA Midwives

Summary of Findings

Ghana was created as an independent country (the first in colonial Africa) in 1957, and declared a republic on July 1, 1960. Ghana has been governed as a constitutional democracy, although governance was interrupted by a series of military coups in the early years of independence. John Agyekum Kufuor took office in January 2001 as the first democratically elected president since independence.

The people of Ghana are in the vast majority representatives of black Africa tribal families. They profess Christian (63 percent), indigenous (21 percent), and Islamic (16 percent) religious beliefs. The literacy rate is 64.5 percent (1995 estimates).

Ghana is a major producer of cocoa, and 60 percent of the labor force is engaged in agriculture. Gold, timber, and industrial diamonds are among the country's natural resources and exports.

The population of Ghana was estimated in 2003 to be over 20 million. This estimate explicitly took into account the effects of excess mortality due to AIDS, higher infant mortality and death rates, and lower population and growth rates. Currently, less than 40 percent of the population is aged 0–14 years, and less than 4 percent is more than 65. The maternal mortality rate was estimated to be 5.9 (Population Reference Bureau, 2002). Forty-four percent of women deliver with skilled birth attendance. The total fertility rate is cited as 3.32 children; 13 percent of women used modern methods of family planning, according to a 1998 estimate.

Infant mortality is cited as 53 per 1,000, although malaria accounts for one fourth of the deaths of children under age five. The HIV/AIDS rate, presently 4.1, is estimated to rise to 7 percent by 2009.

Figure D3
Demographic Indicators

Indicator	Value	Data Unit	Year	Source
Total Population	20,467,747		2003	BUCEN–IDB 2002
Population Growth Rate	1.4	percent	2003	BUCEN–IDB 2002
Percent Urban	38.4	percent	2000	World Bank/WDI 2002
Women, 15–19	1,188,403		2003	BUCEN–IDB 2002
Women, 15–49	5,188,111		2003	BUCEN–IDB 2002
Life Expectancy at Birth	56.5		2003	BUCEN–IDB 2002
Crude Birth Rate	25.8	per 1,000	2003	BUCEN–IDB 2002
Crude Death Rate	10.5	per 1,000	2003	BUCEN–IDB 2002
Number of Live Births	528,887	000s	2003	BUCEN–IDB 2002

PRIME initiated activities in Ghana under PRIME I. Program emphasis in safe motherhood and integration of reproductive health activities into family planning programs were continued into PRIME II. The transition to PRIME II was hampered by the unfortunate and untimely death of the original country director, which resulted in the need for interim leadership, reorientation, and reconfirmation of technical leadership areas and the PRIME II scope of work. The present country director has been well received by the USAID Mission, and has attempted to establish effective communication among other cooperating agencies (CAs) as a hallmark of his administration (32 U.S.–based CAs presently operate in the country, in addition to numerous faith-based organizations and other country agencies). PRIME II works with the government and other NGOs to conduct activities in the following priority areas:

- Community-based Health Planning and Services (CHPS), a Ghana Health Services (GHS) program plan to increase the rural community's access to

basic health services through increased community involvement and participation;

- provider performance improvement in safe motherhood and supervisory skills among CHPS community health officers and regional resource teams (FP/RH trainers); and

- testing of alternative learning approaches (self-paced learning for lifesaving skills and postabortion care).

Conclusions and Issues

Through interviews with USAID, project staff, and partners (including interviews with CHPS supervisors, community health officers, and regional resource team members), observational visits to CHPS compounds and private maternity homes, reading, and unofficial contacts, the following conclusions were drawn about PRIME II's work in Ghana:

- Training appears to be accurately focused, well received, and consistent with PRIME II, MOH, and USAID objectives. There is evidence of good coordination with JHPIEGO in coordinating its preservice training and curriculum with the PRIME II inservice training and modules. There is also coordination with JHU/CCP in the CHPS program, with JHU taking charge of the community mobilization phase, which complements PRIME II's training of community health officers and allows for each to do their jobs in a coordinated way.

- In both of the MOH–supported programs (safe motherhood and CHPS), there is evidence of good coordination with EngenderHealth, which is conducting the facilitated supervision training.

- There is much support and interest in the self-paced learning strategies implemented for the safe motherhood program, expressed by the MOH and CAs. The Population Council is currently evaluating the results of the self-paced learning approach methodology compared with the traditional training approach used.

- The preliminary results of a cost study conducted by the PRIME II office in Chapel Hill, North Carolina, and others indicates that the financial and opportunity costs of the self-paced learning approach are about equal to those of the traditional approach, even though the self-paced learning approach can take more than a year for the midwives to complete.

- Positive feedback has been received on the use of the performance needs assessments conducted for the safe motherhood training activities, despite the fact that it took several months to complete. Staff members at the facilities involved believed the process allowed the administration to buy into the program, and therefore administrative officers later facilitated their efforts to conduct training and other required safe motherhood activities. Further

evidence of MOH support is that the MOH has asked PRIME II to conduct additional performance needs assessments in other regions of the country.

- Observations of midwives in their maternity home settings confirmed that midwives were poised to perform to standard (infection control, equipment readiness) for manual vacuum aspiration (MVA) and other safe motherhood clinical tasks (including PAC counseling and performance of MVA) for which they had been trained by PRIME II. These midwives also demonstrated sensitivity to the needs of adolescents and awareness of the relationship of HIV/AIDS (mother-to-child transmission) to safe motherhood.

- The USAID Mission expressed concern about the amount of time it has taken for PRIME II to demonstrate outcomes of its interventions, although the Mission acknowledges that the transitions in management had an adverse impact (delay) on the time line.

- Although USAID and others see a continuing need for PRIME II–supported activities in Ghana, they do not intend to buy into any of the existing or future cooperative agreements, such as the recently awarded ACQUIRE agreement. The new Mission contracts officer wants to put all new work out for bid beginning with the 2004 budget. The bid will be consistent with the new Mission strategy and health priorities. The Mission expects to make decisions on these new awards in summer 2004.

In summary, PRIME II has made a major contribution in support of the Ghana Health Services' CHPS initiative in the areas of provider training (reproductive health and safe motherhood clinical skills) and focused activities related to the training of supervisory teams (facilitative supervision, behavior change communication). A second major contribution was the development and testing of an alternative learning approach, which is also being addressed presently in terms of its cost-to-benefit ratio, in anticipation of replication and expansion.

PARAGUAY

Dates Visited
September 21–26, 2003

Principal Contacts

USAID
Wayne Nilsestuen, Director
Sergio Guzman, Deputy Director
Graciela Avila, Health and Population Officer
Josceline Betancourt, Health and Population

PRIME II
Gregorio Soriano, Country Director
Elodia Vysokolan, Program Officer
Jorge Sosa, Master Trainer
Felicita Aranda, Technical Supervisor
Angela Espinola, Caaguazu Project Coordinator
Lilliana Villalba, Finance Manager

Host Country Institutions
Centro Paraguayo de Estudios de Población (CEPEP)
Centro de Información y Recursos para el Desarrollo (CIRD)
Encarnación Regional Hospital, Fram Health Center
San Miguel Health Center
Caaguazu Mobile Nursing Clinic Program

Key Persons
Cynthia Prieto, CEPEP
Augustin Carrizosa, CIRD
Dr. Jose Rolon Pose, Fram Health Center
Hermalinda Rojas, Fram Health Center
Dr. Carmen Sorilla de Ramirez, San Miguel
Dr. Maria Teresa Baran, Director, Encarnación Regional Hospital
Aida Palacios Burges, Chief Nurse, Encarnación Regional Hospital
Dolly Godoy, PRIME II Caaguazu Staff
Digna Britez, Coordinator of PRIME II Caaguazu Community Activities

Summary of Findings

Because of Paraguay's relative isolation and slow development, due in large part to its having been ruled by the Stroessner dictatorship for more than 30 years (1958–1989), Paraguay is only now experiencing many of the trends that emerged years ago in other Latin American countries. Urbanization (currently 52 percent is urban) is coupled with an annual population growth rate of 2.6 percent, which will cause the population to double in 25 years. Despite this trend towards urbanization, more than 40 percent of the population remains engaged in agricultural activities, and approximately 20 percent of all families depends on cotton farming.

Historically, Paraguay has the least experience of democratic rule among its South American neighbors and is currently one of the hemisphere's weakest democracies. This is reflected in its slow progress towards decentralization, demonopolization of state enterprises, and privatization. The populace is still learning such basic democratic practices as voting, citizen participation, advocacy, freedom of expression, and respect for opposing views.

The demographic situation in Paraguay resembles that which was found elsewhere in developing countries 50 years ago. Forty-one percent of the population is less than 15. Public health services are dominated by a clientele of women and children. A recent USAID survey confirms that women and children account for 89 percent of patients at MOH services;[2] two thirds of these have only a primary education. The average number of births to women dropped from 4.7 in 1990 to 4.1 in 1998, but it is still high. When urban–rural factors are considered, there is a total fertility rate of 3.2 in the cities and 5.6 in the countryside (where about half the population resides). In rural areas, less than half the women use family planning methods and more than one fourth have five or more children. The 1995 Reproductive Health Survey revealed a maternal mortality ratio of 192 per 100,000 live births, but because of measurement difficulties, some experts believe that this figure could be as high as 262 deaths per 100,000. According to MOH reports, poorly performed abortions account for 30 percent of these deaths. In addition, 40 percent of all births occur at home without assistance from a trained provider. In rural areas, 60 percent of women deliver in their homes, assisted only by untrained traditional birth attendants. For all these reasons, USAID has been supporting reproductive health interventions at primary service delivery levels as well as strategies to improve maternal and neonatal care.[3]

Figure D4
Demographic Indicators

Indicator	Value	Data Unit	Year	Source
Total Population	6,036,900		2003	BUCEN–IDB 2002
Population Growth Rate	2.5	percent	2003	BUCEN–IDB 2002
Percent Urban	56	percent	2000	World Bank/WDI 2002
Women, 15–19	299,463		2003	BUCEN–IDB 2002
Women, 15–49	1,458,957		2003	BUCEN–IDB 2002
Life Expectancy at Birth	74.4		2003	BUCEN–IDB 2002
Crude Birth Rate	30.1	per 1,000	2003	BUCEN–IDB 2002
Crude Death Rate	4.6	per 1,000	2003	BUCEN–IDB 2002
Number of Live Births	181,952	000s	2003	BUCEN–IDB 2002

Although PRIME II has had a slow and difficult start in Paraguay (having changed country directors twice since it began in 2001), everyone seems pleased with the current country director, who began in May 2003. This director previously worked as PRIME II's regional monitoring and evaluation officer, so he is familiar with PRIME's goals and understands the situation in Paraguay. As a result, he has been able to step in quickly and reorganize the office as well as bring focus to the interventions. The USAID Mission and most partner agencies appear pleased with PRIME's new focused activities. He directs a

[2] USAID/Paraguay Strategic Plan for FY 2001–2005.
[3] Ibid.

talented staff of professionals who work with the government and other NGOs to conduct activities in three areas to

- expand access to reproductive health services among rural and low-income women in four areas: Central, Misiones, Itapua, and Asunción;

- improve the quality of reproductive health care offered in hospitals and health centers in Central, Misiones, Itapua, and Asunción; and

- improve policies related to reproductive health at the national level.

Due to a reorganization of PRIME's geographic areas and priority activities after the midterm evaluation in January 2003, its focus is now mainly on the second (quality) and third (policy) areas mentioned above. The partners working with PRIME on the Alliance Project are taking more responsibility for the first area of improving community access to services.

Conclusions and Issues

Through facility visits in Itapua and Misiones provinces, interviews with USAID and project staff and partners, reading, and unofficial contacts, the following conclusions were drawn about PRIME II's work in Paraguay:

- USAID and the cooperating agencies are very pleased with the present PRIME II director and the skills of his team.

- The director seems to have surmounted the adverse impact of the two prior directors. USAID mentioned having been pleased with the timely response of the PRIME II regional and headquarters offices when management problems and issues were brought to their attention.

- Training activities appear well targeted to country needs and well adapted to learner and resource levels.

- PRIME II has attempted some innovative information technology strategies and methods, including videoconferencing of medical procedures, computer-assisted interactive teaching and learning methods, and Internet database access for evidence-based research.

- Performance improvement methodology is very strongly integrated into every country activity. Specific successes were mentioned in relation to infection prevention and informed choice/patient confidentiality.

- Evaluation team members were able to debrief the PRIME II consultant who is completing an extensive series of community forums related to the new reproductive health strategy being developed with the government of Paraguay. There are plans to use the same community forum process at the time of dissemination of the new strategy (responding to a major critique of the prior strategy dissemination process).

- The safe motherhood project in Caaguazu has had productive training of trainers sessions, having trained 18 trainers who in turn have successfully trained 80 traditional birth attendants in safe motherhood practices. Work has begun with communities to develop referral and emergency plans. To date, 15 communities have emergency obstetric action plans.

- The project has made good use of the director's skills and regional experience. In the area of teaching and learning, he has brought in proven methodologies from Nicaragua (safe motherhood, American College of Nurse-Midwives) and Honduras (facilitated supervision). He also brought monitoring and evaluation experience to bear on the program.

- There appears to be strong interest and support from USAID/Paraguay for continuation of the majority of current programs as they do not see local agencies ready to assume these responsibilities. PRIME II should be strongly encouraged to develop strategies for the transfer of learning and methodologies to local organizations and people.

There are some clear difficulties establishing boundaries and commonalities with local NGO partners involved in *Alianza*, the project partnership set up by USAID/Paraguay for PRIME II, Centro de Información y Recursos para el Desarrollo (CIRD), and Centro Paraguayo de Estudios de Población (CEPEP). This has caused some delays and emphasizes the need to continue to clarify roles and responsibilities among the three projects so that coverage is comprehensive.

In summary, PRIME II had a slow and difficult start in Paraguay, but it is presently on course and likely to complete all tasks.

APPENDIX E

PRIME II SELF–ASSESSMENT
(from PRIME II)

Responding to the Self Assessment Questions

1. The PRIME Project's **focus on primary providers** is appropriate and important. Evidence is clear that both a broader definition of primary providers (to include community level providers, private sector providers such as pharmacists, volunteers and others) and an expanded role for these providers will contribute significantly to addressing the growing demands for quality health care services caused by pressures such as the HIV pandemic and the bourgeoning cohort of youth entering reproductive age.
2. The PRIME project is on track to meet all the objectives of the cooperative agreement and to **provide results** as required by the performance monitoring plan. These results show a direct link between the use of performance improvement and related approaches and improved provider performance.
3. Evidence continues to show that **training is not always the answer** to performance and service delivery problems, that training alone is not enough, and that even when training is the right intervention, it can be improved through techniques such as blended approaches tailored to the situation.
4. The **PI approach is content-neutral** and can be applied to various technical areas such as family planning, STI and HIV, safe motherhood, and postabortion care.
5. PRIME has produced important **learning about how to improve provider performance** and quality service delivery, particularly in the areas of:
   - Consumer feedback mechanisms
   - Use of innovative and blended learning approaches (such as distance learning and self-directed learning)
   - Non-training interventions (such as clear performance expectations, supportive supervision and provider motivation).
6. **There is more work to be done**, especially in the areas of:
   - *Broadening the application of PI* to fields beyond family planning, which can offer critical support to the human capacity development challenges posed by the HIV pandemic
   - *Scaling up the use of the PI approach* and ensuring its sustainability, which includes learning more about the scale up process, how the approach can be customized for use in different contexts and how to make it an on-going process and not just a one-time diagnostic approach
   - *Taking the PI approach to next level*, which includes developing and documenting more experience on non-training interventions such as motivation, supportive supervision, human resource allocation, job satisfaction and employee retention
   - *Scaling up the use of approaches that make training more effective and cost-efficient*, starting with performance needs assessments (PNAs) and including approaches such as implementing complementary training and non-training interventions as indicated by PNAs, applying the performance learning methodology, use of innovative and blended learning and improved use of information technology
   - *Advocating for recognition, support and an expanded role for primary providers* in order to meet growing health care needs.
7. PRIME has provided technical leadership and produced impressive results, successfully managed a large, complex project with significant field support contributions using a decentralized management model, maintained strong and supportive working relationships with USAID/Washington and missions and pioneered a successful partnership model.

Question 1. Within each Technical Leadership Area (TLA) before July 1, 2003, describe results and lessons learned.

During the first quarter of PRIME II, the Partner Leadership Group, Project staff and USAID/Washington approved the formation of four global technical leadership areas (TLAs) where PRIME would focus much of its core funding support and commit to five-year strategies for each technical innovation:

- **Performance Improvement (PI)**
- **Responsive Training and Learning (RTL)**
- **Postabortion Care (PAC)**
- **Consumer-Driven Quality (CDQ)/Integrating Consumer Perspectives (ICP).**

These TLAs are consistent with PRIME's mandate and support the Project's Results Framework. Both content and technical-approach driven, TLAs are areas where PRIME I had already made headway in testing models and where PRIME II has pushed the envelope with creative new strategies.

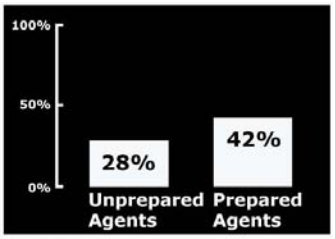
Each year PRIME has built on lessons learned in each TLA working within the context of the long-term strategy, and identified opportunities to link content areas, such as PAC, with a technical approach like Performance Improvement. Late in Year 4 of the Project, PRIME evaluated the status of the CDQ TLA; lessons learned indicated the Project had a highly useful approach that would be best sustained as part of the PI Framework. In June 2003, the CDQ TLA was incorporated into the Performance Improvement TLA and renamed Integrating Consumer Perspectives. In July, after discussions with USAID/W, the Partner Leadership Group and Project staff, PRIME introduced a new TLA: HIV/AIDS Integration with Family Planning. In this section we are presenting results for the original four TLAs.

Performance Improvement

For project design, implementation and evaluation, the Performance Improvement approach has become the way we do business in PRIME II. Carrying out 28 performance needs assessments (PNAs) in 18 countries, PRIME has shown PI to be a dependable methodology for identifying gaps in health care worker performance and designing and selecting interventions to close those gaps. By applying and scaling-up PI and supporting approaches, PRIME II has identified and built the capacity of a wider range of primary providers, expanding service delivery and reaching more people with critical FP/RH services.

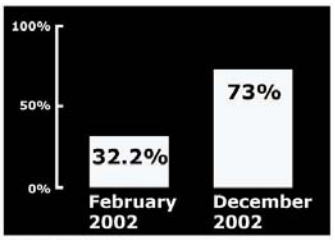
Through PI, PRIME has demonstrated the importance of non-training interventions to solve performance gaps caused by factors other than knowledge and skills. In turn, using the PI approach has helped project stakeholders become more aware of the limitations of training as a stand-alone intervention, encouraged collaboration among stakeholders and CAs, and engaged health care leaders in family planning and reproductive health (FP/RH) policy dialogue. Products and results of PRIME II's application of PI throughout the world have been widely disseminated through short courses, publications and conferences, equipping clients and colleagues with guidance and tools to apply the PI approach in their own organizations, systems and projects.

Results



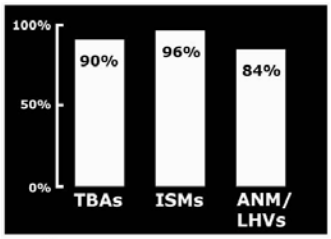
Benin:
Pharmacy Agents Carrying out Counseling and Method Distribution Satisfactorily

- **Benin:** The 2001 DHS showed high unmet need for FP in Benin, where the average woman bears six children and only 7% of married women aged 15 to 49 are using modern contraception. In response, PRIME II applied PI in the private sector to assess and prepare a new cadre of 140 pharmacy agents to improve the quality of FP counseling and increase provision of oral contraceptives in the two largest cities, Cotonou and Porto Novo. A year after training and non-training interventions, including better job definitions and development and use of job aids, an evaluation found prepared agents performing significantly better than unprepared agents in five areas of care (42% vs. 28% of all tasks carried out satisfactorily).

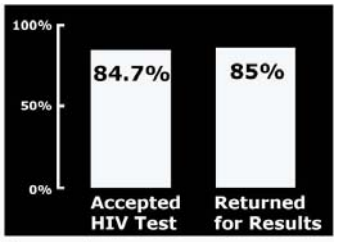


Paraguay:
Primary Providers Performing to Standard

- **Paraguay:** PRIME II developed a model to assist the MOH in improving the quality and accessibility of RH care in five geographic areas. A project review visit after ten months of implementation showed that primary providers in sampled regions increased quality of care in five priority areas (counseling, informed consent, technical competence, client-provider interaction and availability of methods) from 32.2% of tasks performed to standard in February 2002 to 73% in December '02.
- **Nicaragua:** To help reduce high maternal mortality levels in the Jinotega region, PRIME II improved the performance of over 160 TBAs, physicians, nurses and community leaders and strengthened provider and community preparation for deliveries and obstetric emergencies. Community mobilization activities included developing birth preparedness and complication readiness plans, setting up emergency obstetric and neonatal care committees, pooling emergency funds and establishing transportation plans to ensure women and newborns can reach referral facilities in the event of an emergency. Observation by experts and consumers documented significantly improved maternal care practices by providers including a 20% improvement in management of postpartum hemorrhage and a dramatic reduction in TBAs using injections to "hurry labor" (3.6 times less than at baseline).



India:
Primary Cadres Performing to Standard after Training and Support



Rwanda:
Voluntary Prenatal Counseling for HIV and PMTCT, Kibuye Hospital

- **India:** After a PNA to ensure that all performance factors were taken into account, primary FP/RH providers were trained and supported by PRIME II in wide areas of Uttar Pradesh. All cadres have consistently achieved high levels of performance to standard: TBAs (90% of 6,948 assessed), Indigenous System of Medicine (ISM) practitioners (96% of 5,404 assessed) and Auxiliary Nurse-Midwives/Lady Health Visitors (84% of 6,459 assessed).
- **Rwanda:** Even when necessary drugs are available, prevention of mother-to-child transmission (PMTCT) of HIV in Rwanda is a major challenge, especially since less than a third of all deliveries are assisted by skilled personnel. In three sites, PRIME is helping providers improve voluntary counseling and testing of prenatal clients. These efforts are paying off: data from March 2002 to June 2003 reveal, for example, that 1167 clients have been counseled for HIV and PMTCT at Kibuye Hospital; 84.7% accepted the HIV test and 85% of those women returned for their results.

Lessons Learned

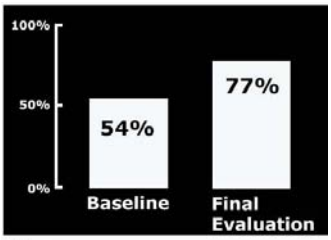
- Performance Improvement works in low-resource FP/RH settings, and the knowledge and skills necessary to build capacity to carry out PI can be transferred to counterparts. At the same, PRIME continues striving to refine PI so that the process is simpler and faster.
- The Obtaining and Maintaining Stakeholder Agreement stage of the PNA/PI process is vital as it ensures that those in decision-making positions support a project for its duration. PRIME has found that closely involving stakeholders increases transparency, helps clients and stakeholders own the process, makes it easier to prioritize performance problems, decreases the risk that personal biases will unduly influence outcomes, and increases opportunities for learning—and project sustainability—on the part of local counterparts.
- Defining Desired Performance is perhaps the most important stage of the PNA and is almost an intervention by itself since stakeholders often have not considered or clearly defined desired performance. While stakeholder groups can agree easily on generalities of performance, describing desired performance in observable and measurable indicators frequently becomes a much more involved process.
- Reducing the number and reaching agreement on the best interventions to close the performance gap(s) remains a challenge. This is especially true if the PNA process involves a large number of stakeholders. The tendency of such groups is to want to fix every problem, so prioritizing and sorting interventions based on group-derived criteria is an essential step. PRIME's experience indicates that, once interventions are chosen, it frequently becomes clear that many performance factor problems are inexpensive to correct. The very process of PI helps managers and teams resolve non-monetary and often neglected causes of

performance problems, in particular unclear job expectations and priorities.

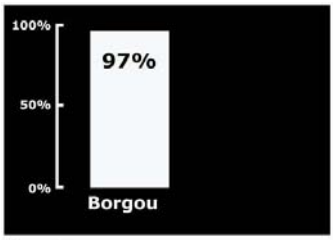
- PRIME is learning important lessons about the potential of certain non-training interventions over the remaining year of the project. Interventions are being tested to help close performance gaps by setting clear performance expectations based on national guidelines, helping providers solicit and use feedback from clients, and using public posting of performance data as a motivational device.

Responsive Training and Learning (RTL)

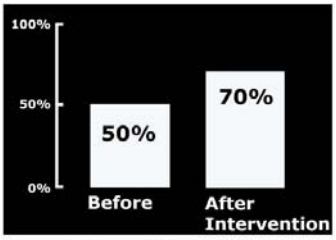
Recognizing that classroom-based training remains the most frequently used configuration, PRIME II has continued to improve that "classical" approach while developing others that are more suitable to the primary providers' environments. Several examples described below show how PRIME has succeeded in taking training "beyond the classroom." While the PI approach demonstrates that training alone rarely provides a comprehensive solution to a performance or service delivery problem, a majority of PRIME II's PNAs have revealed the need for a learning intervention to close performance gaps caused by lack of knowledge and skills. PRIME has used evidence-based practices to develop a variety of blended learning approaches designed to effectively transfer knowledge and skills to improved job performance in low-resource settings.



Ghana:
Midwives Performing to Standard in CPI and Counseling Skills



Benin:
Providers Appropriately Using Protocols



Dominican Republic:
Knowledge among Volunteer Promoters in Rural *Bateyes*

Results

- **Ghana:** Building on a self-directed learning intervention implemented during PRIME I for midwives in three regions, PRIME II supported the development of a module on HIV/AIDS and trained an additional 52 private midwives. The modular course and monthly meetings improved overall provider performance in CPI and counseling skills by 43%.
- **Benin:** PRIME II implemented a blend of traditional classroom training, tutoring and self-directed learning to enhance the dissemination of revised national RH protocols in the Borgou, Atlantique and Mono regions. As a result of this approach, providers (physicians, midwives, nurses) in all three regions significantly improved their knowledge test scores in STIs, infant health and safe motherhood, and earned high observation scores (e.g., 97% in Borgou) on use of the protocols for STI/HIV/AIDS, safe motherhood, child health and infection prevention.
- **Dominican Republic:** PRIME used traditional classroom, self-directed and peer-assisted learning approaches along with supportive radio programming to train volunteer FP/STI/HIV/AIDS health promoters working in isolated and marginalized slum communities (bateyes). The combination of methods produced gains in knowledge for the promoters (50% to 70%).

- **Bangladesh:** PRIME and local stakeholders in the National Integrated Population and Health Program identified important content areas that had not been adequately covered during formal pre-service training sessions for paramedics, and designed a pilot distance-based learning program to build knowledge and skills in these areas. Initial results show that participating paramedics made slight gains in knowledge and significant gains in skill levels for postnatal care and management of mothers with insufficient breast milk (35% and 27% improvement, respectively, over baseline).

Lessons Learned

- PRIME II's experience designing and implementing blended approaches has confirmed that training interventions must be performance-focused and combined and coordinated with non-training interventions to ensure transfer of learning to the workplace and improved performance on the job. Combinations of training and non-training approaches are effective when they are based on performance behaviors, learning needs and systematic instructional design as well as contextual and cultural factors that can affect performance in the workplace.
- The performance improvement consulting process often involves familiarizing planners, trainers and managers with evidence-based training practices and helping them monitor and evaluate pilot programs. Despite this, project planners and trainers tend to gravitate toward approaches and methods they are familiar with, and there has been a strong tendency to request classroom-based training. PRIME has found, however, that training professionals are receptive when alternative learning approaches are tailored to respond to the particular needs of learners and organizational resources.
- Technology can be applied effectively for learning in low-resource settings. Piloting and careful monitoring are necessary to ensure that the right technology is matched to the situation, especially when introducing a new technology. (See IR1, Question 4, for more detail.)

Blended learning approaches:

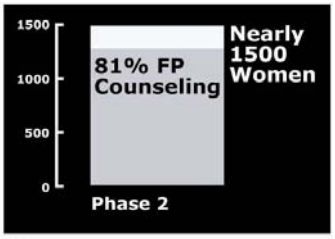
- Need the active involvement of key stakeholders at all levels to ensure success and commitment to implementation
- Require clear, practical, engaging materials that convey the structure of the learning experience
- Require a strong, effective learner support system
- Can be designed to allow learners to apply new knowledge and skills as soon as they are learned, given the appropriate guidance from facilitators
- Are effective in developing clinical as well as cognitive skills

- Allow flexibility in scheduling and can reduce the number of consecutive days away from the job for training
- Provide the opportunity to stagger training events to address the issue of insufficient clinical practice due to too many learners for too few clients
- Are most effective when they are carefully designed and monitored during implementation so adjustments can be made as necessary.

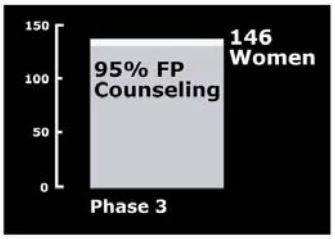
Postabortion Care (PAC)

PRIME II has demonstrated that well-trained, equipped and supported mid-level providers (e.g., nurses and midwives) at primary-level facilities can offer high-quality PAC services, including manual vacuum aspiration for uterine evacuation, and that PAC increases the availability and use of FP. PRIME strives to ensure that all postabortion women are offered FP counseling and services before leaving the facility and are also offered appropriate STI/HIV services (including counseling and testing) or referred for these services to another facility in the providers' network. PRIME offers technical leadership for the expansion and scale-up of primary-level PAC services both geographically and to underserved groups. All PAC work during PRIME II has used a Performance Improvement framework to ensure that interventions target the root causes of performance problems.

Results



Kenya:
Phase 2 PAC Clients
Receiving FP Counseling



Kenya:
Phase 3 PAC Clients
Recieving FP Counseling

- **Kenya:** To address high rates of maternal mortality and morbidity due to unsafe and incomplete abortion, PRIME II trained private-sector nurse-midwives working in three of Kenya's seven provinces in postabortion care including emergency treatment and family planning counseling and services. During Phase II of the project, 155 trained providers successfully treated nearly 1500 women with postabortion complications using MVA and counseled 81% of these women in FP, resulting in 56% leaving with or agreeing to return for a FP method. Phase III scale-up is ongoing in a fourth province—as of July 2003, 43 providers have been trained and 146 clients successfully managed using MVA; 95% of clients have been counseled in FP with 75% accepting FP methods.
- **Ghana:** As part of the MOH's Safe Motherhood program, PRIME II scaled-up PAC in three northern regions using a self-paced learning approach. Results are forthcoming (from a June 2003 assessment and global partner Population Council's final evaluation in October 2003) on provider performance, quality of care and client use of FP methods, as well as cost-results data.
- **PAC expansion:** The Francophone PAC Conference in March 2002 successfully launched PRIME II's efforts to move PAC to the primary level in Senegal, Benin and Guinea. In Senegal,

PRIME is increasing access by taking selected PAC services, not including MVA, to the community level, enhancing referrals and links with tertiary facilities that provide MVA (results forthcoming).

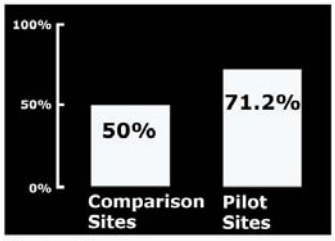
- **Kyrgyzstan:** Interviews and observations with 26 abortion providers and 104 abortion clients identified performance gaps and barriers to the availability and use of postabortion FP. Results of PRIME's research and interventions will have wide applicability throughout the former Soviet Republics where rates of repeat abortion are high and use of modern contraception lags behind other parts of Europe and Asia.

Lessons Learned

- PAC is a sensitive issue that attracts negative attention if not handled skillfully. Influential and credible in-country partners are essential to advance the PAC agenda. Support from medical associations of ob/gyns and midwives is crucial.
- Often, postabortion women are at risk of STI/HIV because they have had unprotected sex. PAC providers must be an active link in the network for HIV counseling and testing services, as well as other priority STI services such as education, diagnosis, testing and treatment.
- The traditional "health pyramid" in most countries does not take into consideration nor allow for adequate assistance to community-supported providers. To alleviate the problem, it is often necessary to forge new partnerships, which can cause delays in implementation as well as unanticipated costs.
- The message that PAC is more than just MVA is slowly being heard and understood. However, PAC programs need to become more integrated with Safe Motherhood and RH programming and funding.

Integrating Consumer Perspectives (ICP)

PRIME II has increased the quality, accessibility and use of FP/RH services by incorporating consumer perspectives and fostering consumer-provider partnerships. Initially carried out through the Consumer-Driven Quality (CDQ) TLA, these efforts are now part of the Performance Improvement TLA. An ICP toolkit for gathering consumer input is being tested through applications in Nicaragua, Zambia and the Dominican Republic and several of PRIME's interventions now incorporate consumer feedback for health care improvements.

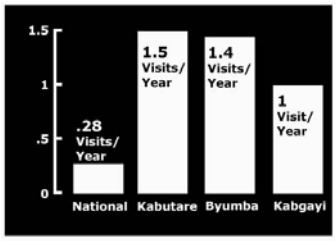


Uganda:
Adolescent Use of Family Planning Methods

Results

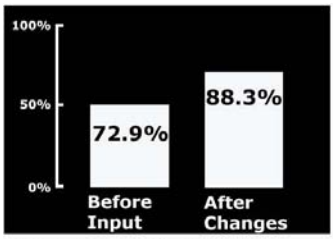
- **Uganda:** Responding to high rates of unintended pregnancy and STIs and very low usage of RH services, PRIME II worked with adolescents, community leaders and primary providers to design and establish adolescent-friendly services in Jinja district.

Improved provider knowledge, practices and approaches encouraged adolescent attendance at RH facilities. As a result, six times more adolescents attended the pilot clinics than the control clinics (5,419 vs. 788) and adolescents reported higher current use of FP methods (71.2% vs. 50.0%) in the four months after completion of the intervention. Through the bilateral DISH II project, this pilot has been expanded to the national level.



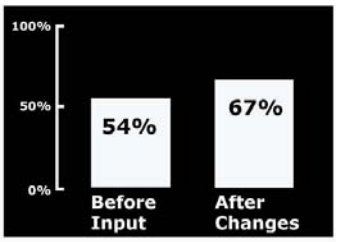
Rwanda:
Average Number of Visits to Health Facility per Year

- **Rwanda:** Building on the existing health care financing system of community-based prepayment schemes (mutuelles), PRIME II has worked to increase accessibility and use of primary RH services in three districts that contain 15% of Rwanda's population. Enlisting community health staff (including social workers) and responding to consumer needs, activities have increased mutuelle membership and use of services (1.5, 1.4 and 1 visit per year/member in Kabutare, Byumba and Kabgayi districts, respectively, in contrast to the national rate of 0.28 visits).



Dominican Republic:
Clients Satisfied with Services

- **Dominican Republic:** PRIME II assisted ADOPLAFAM, a local FP NGO, to expand and improve services through a client-centered approach. Introducing mechanisms to collect consumer input (e.g., creation of a clinic-community committee that meets regularly; expanding community health promoters) led to changes in service delivery (including added gynecological and vaccination services and improved privacy), enhanced client satisfaction with services (from 72.9% to 88.3%), and a more than 100% increase in use of services over a 12-month period.



El Salvador:
Increase in Adolescents Going for Prenatal Care

- **El Salvador:** Incorporating input from adolescent consumers, PRIME II technical assistance at three pilot hospitals between 1999 and 2001 helped to change approaches (e.g. personalizing care, reducing judgmental attitudes), increase prenatal visits (from 54% to 67%) and enhance client satisfaction (from 84% to 95%).

Lessons Learned

- Providers must be flexible when working with consumers (clients and potential clients) as they tend to be extremely busy with jobs and families. Often, project activities such as meetings must take place during evenings and weekends rather than when most convenient for providers. Providers must be ready to go where consumers gather, such as schools, churches, stores and community centers.
- Clinic providers can be effective mobilizers of consumer input, but must be receptive, open and ready to accept consumers' point of view. They must be adequately prepared to minimize the negative impact of provider bias on their interaction with consumers.
- Service delivery leadership must facilitate and support providers work in the community and "go the extra mile" to ensure consumers know they've been heard.

Question 1. Describe how PRIME has strengthened pre-service, in-service, and continuing education systems.

PRIME II's work in this area has been guided by the principle that strong linkages among pre-service, in-service and service delivery systems will lead to more efficient human capacity building by reducing training redundancies and lessening the burden of multiple vertical FP/RH programs on the FP/RH workforce.

PRIME has strengthened pre-service training (PST) in six countries and in-service training (IST)/continuing education (CE) systems in 13 countries by applying a variety of strategies and techniques, always taking into account the context of the country and the potential scope of influence. Illustrative examples include:

- Collaboration with ministries of health to design and implement training systems that reflect the goals of large-scale government decentralization efforts (Bangladesh, El Salvador, Tanzania)
- Use of performance needs assessments (PNAs) to inform processes and guide decision-making on appropriate interventions for strengthening existing systems or components of systems (many countries)
- Fostering linkages among PST and IST representatives who oversee professional associations and the MOH and/or MOE to ensure consistency across multiple systems (PAC activities in Kenya; curricula for community midwives in India)
- Encouraging government partnerships with the private sector, NGO agencies and communities to maximize limited human and financial resources (Zonal Training Centers in Tanzania; Lead Training Organizations in Bangladesh)
- Establishing formal technical advisory/working groups for joint planning of PST and IST strategies and curricula (Armenia, Mali)
- Influencing expectations for training quality by adopting national training standards (Bangladesh, Mali) and procedure guidelines (Rwanda)
- Offering technical updates on reproductive health and family planning to stimulate interest in improving training systems and/or curricula (Dominican Republic, Benin, Rwanda)
- Creating training management systems that allow decision-makers to monitor training activities and track performance (Bangladesh)
- Developing high-quality training and practicum sites to ensure that heath workers are deployed or return to their work sites with the skills they need to perform to standard (auxiliary nurse-midwives and community midwives in India).

To create sustainable solutions within all levels of training and continuing education systems, PRIME collaborates with in-country colleagues to identify the best strategies and necessary resources. Such collaboration often begins with specific skill-building workshops (e.g., conducting a PNA, costing/financial/work planning) but always offers opportunities to "learn by doing" with ongoing technical assistance from PRIME staff. PRIME also promotes a blended learning approach that leads to greater retention of knowledge and skills and is often more cost-effective and less disruptive than straight classroom training.

PRIME encourages in-country colleagues to maintain high standards and use a systematic process even when formal processes and systems are not in place. In Armenia, for example,

PRIME and local partners created protocols for nurses as part of the training intervention so that the protocols could then be endorsed by the MOH and used to facilitate understanding among physicians and nurses about their changing roles and scopes of work.

Additionally, PRIME sought approval from the MOH for the strategy and curricula that were developed; even though national implementation is not part of PRIME's mandate, validation by the MOH makes national scale-up possible.

What were the lessons learned?

In addition to lessons learned described above:

- PRIME developed a strategy in El Salvador that allowed the national university to build the knowledge and skills of medical students in family planning before the subject was officially added to the curriculum. Although official curriculum revisions are planned, the process can take a long time. In the interim, students are getting credit for extracurricular FP training activities that have been incorporated into their rural internship experience, thus improving the overall quality of their services to the community.
- During the scale-up of the Kenya PAC Phase 2 initiative, PRIME helped introduce a non-training intervention to facilitate peer support for nurse-midwives recently trained in PAC. Designed to ensure that providers receive the support they need after learning new skills and adding new services, the peer groups are based on existing informal networks and alliances that the nurse-midwives had developed to assist each other with clinical problems. Initial feedback on the peer support networks was so positive that this component of the project was expanded to Phase 3 (Coast Province) even before the formal evaluation of Phase 2 had been completed.
- PRIME has gained additional experience in developing pre-service training and education programs despite the frequent tendency of host-country partners and donors to look for a "quick fix" via in-service training. While the process is arduous, PRIME has found that fostering linkages among pre-service institutions, in-service programs and service delivery points to balance training needs yields results, particularly if a multi-year program is envisioned. Because PST and IST systems often reside in separate ministries, however, it can be difficult to mobilize the right stakeholders. When they exist, national FP/RH guidelines provide a key link among PST, IST and service delivery systems.

Question 2. How many Performance Needs Assessments has PRIME done? What were the lessons learned?

PRIME II has conducted 28 performance needs assessments (PNAs) in 18 countries as of August 1, 2003. Many more will be conducted during the final year of the Project.

A broad range of stakeholders have been involved in the PNA process. Depending on the country and scope, they include NGOs, CAs, other donors, clinic staff, primary providers, clients and community groups.

The amount of time it takes to complete a PNA has ranged widely, from four days to more elaborate exercises that have stretched over several months. A variety of factors determine the timeframe including the number and complexity of performance issues being addressed, resources available, number of stakeholders, quality of pre-existing data and amount of data collected.

Training Alone is Not Enough

The main lesson learned from conducting these PNAs is that training alone is often not enough to improve provider performance and service quality. When partners are resistant and insist on training only, PRIME has found it useful to agree to the request but gain permission to ask additional questions to "make sure the training sticks." Through these questions, other performance factors may emerge and be addressed to help ensure providers receive all the support they need.

Involved Stakeholders are Vital

The Obtaining and Maintaining Stakeholder Agreement stage of the PI process is vital as it ensures that those in decision-making positions support the project for its duration. In addition, those who are closest to the service provision context contribute to the process, making project design and implementation smarter and more field-oriented. PRIME has found that closely involving stakeholders increases transparency, helps partners and stakeholders own the process, makes it easier to prioritize performance problems, decreases the risk that personal biases will unduly influence outcomes, and increases opportunities for learning—and project sustainability—on the part of local counterparts. This stage of PI, in particular, is associated with great variation and unpredictability in process. The time required to obtain stakeholder agreement at all levels can be substantial.

Carefully Articulated Desired Performance Definitions Yield Realistic Performance Goals

Defining Desired Performance is perhaps the most important stage of the PNA and, surprisingly, sometimes the most difficult. Without knowing precisely the goal of the intervention, the remainder of the PI process could easily stray off course. Spending time and scarce resources trying to improve performance that is not truly beneficial to clients is undesirable. While stakeholder groups can agree easily on generalities of performance, describing desired performance in observable and measurable terms takes much longer. It is often helpful to start with some guidelines such as international protocols. Ultimately, this rigorous but vital stage yields performance indicators that all stakeholders can agree on.

Involving a wide array of stakeholders—including the providers whose performance is under scrutiny—ensures that performance goals are important, realistic and integrated with other health care goals of the region and country.

Prioritized Interventions Focus Efforts

Reducing the number of desired interventions and reaching agreement on the best interventions to close the performance gap(s) remains a challenge. This is especially true if the PNA process involves a large number of stakeholders. The tendency of such groups is to want to fix every problem, so prioritizing and sorting interventions based on agreed-upon criteria is an essential step. The process of PI helps managers and teams recognize that not all performance problems are expensive to address and helps them see neglected causes of performance problems (e.g., unclear job expectations and priorities).

Effective Monitoring is Ongoing

PRIME's experience with the Monitoring and Evaluation stage of PI indicates that it needs to be a part of the methodology throughout the process. If sound indicators are chosen during the Define Desired Performance stage, monitoring and evaluation throughout the remainder of the project will be greatly simplified. The amount of data required to determine actual performance levels varies from project to project and sometimes presents challenges.

Question 3. Describe the learning approaches developed, tested and used for primary and non-traditional providers.

PRIME II has improved primary provider performance by developing and implementing practical and effective blended learning approaches and interventions designed for low-resource settings. Blended learning refers to combining two or more training delivery methods to transfer learning based on objectives and the availability and cost of options as well as the learner's degree of independence, motivation, access and familiarity with the media.

PRIME has customized performance-focused, blended learning approaches in a variety of contexts and with different levels of learners as illustrated by:

- Community–based, small group, peer-facilitated learning (Dominican Republic)
- Clinic-based, small group learning combined with internships (Bangladesh)
- Community-based, expert-facilitated learning (India)
- Classroom-based, expert-led learning (El Salvador, India, Paraguay, Mali, Rwanda, Kenya, Ghana, Uganda, etc.)
- Classroom-based combined with self-directed learning and tutorials (Benin)
- Interactive video simulation (Kenya)
- Orientation and on-the-job training (Bangladesh)
- Distance learning using classroom training combined with newsletters (Bangladesh)
- Self-paced learning:
  - Self-directed, paired learning with facilitated clinical practice (Armenia and Ghana)
  - Self-directed, peer- and facilitator-supported learning approaches for knowledge and CPI counseling skills (Ghana).

What were the lessons learned?

Combinations of Interventions Are Powerful

Performance problems in low-resource environments are complex and typically cannot be solved by one intervention. Hence, performance improvement and training interventions should be combined and aligned for maximum impact. By applying the PI process and using data from a performance needs assessment, more effective training approaches can be designed with a greater likelihood of sustainability. Just as the PI approach considers multiple performance factors, using an appropriate combination or blend of learning approaches can improve the transfer of learning to performance in the workplace. Blended learning approaches engage learners in ways that simulate on-the-job experiences and situations. As described in the response to question one, PRIME has shown that self-paced, blended learning approaches can be effective in developing clinical as well as cognitive skills. Blended learning approaches can also decrease extended absences from the workplace for training, offer flexibility for learners and instructors—especially when self-

paced learning is used—and allow for sufficient clinical practice by staggering clinical training schedules.

In Uttar Pradesh, India, PRIME trained auxiliary nurse-midwives (ANMs) using participatory and experiential adult learning principles, Zoe models and supervised application of new skills in clinical settings. ANMs moved from 0% performing-to-standard to over 80% after a six-day clinic-based training in IUD insertion/removal, family planning counseling, screening for STIs/HIV and infection prevention skills. Learning guides, take-home exercises, checklists and small-group peer-learning sessions using the guides were part of the ANM training curriculum.

Additionally, PRIME is testing the use of simulation-based learning technology in low-resource settings and expects to demonstrate applications in the final year of the project. As described in the answer to question five, technology, when combined with other learning methods, shows great promise to enhance transfer of knowledge and skills and simulate the workplace environment.

Combining interventions creates a significant and important challenge for evaluation, but as PRIME has enhanced its evaluation techniques the Project is becoming more able to separate variables and link training to performance. Understanding this linkage improves the capability to design more powerful interventions.

Training Must Focus on Provider Performance

For effective training, program designers and trainers must focus on providers' workplace performance rather than simply improving knowledge and skills. To avoid the common tendency to pack too much content into training, PRIME advocates a systematic approach for designing learning experiences and is investigating a methodology to make training most efficient by reducing curricula to its essential elements. The Performance Learning Methodology includes tools to filter out training content not directly related to job performance.

The design and implementation of training must ensure that learners can apply their knowledge and skills on the job. To assist managers, training developers, trainers and health care workers with this process, PRIME II and JHPIEGO jointly researched and developed The Transfer of Learning Guide based on the best available evidence and our collective experiences in ensuring that training leads to performance improvement. PRIME II also developed and disseminated an interactive CD and website of The Transfer of Learning Guide. The guide uses a matrix to outline specific techniques that supervisors, trainers, learners and co-workers can use before, during and after a training intervention to promote the transfer of learning to job performance. Many of these techniques involve non-training interventions to address the systems and performance factors that enable learners to apply new knowledge and skills.

For Learning to be Sustained, Learners Must be Supported

Supporting providers in the training and learning process and the transfer of learning to the workplace is critical for the success of any training intervention. It is difficult to transfer learning to the workplace, and therefore to improve performance, if learning is not supported by co-workers, supervisors and trainers, as well as by other organizational performance factors. In addition to receiving organizational support, individuals can support each other using peer learning methods or combinations of methods that include peers.

Context Must Be Considered in the Design and Implementation of Interventions

Provider performance is strongly influenced by the context in which health care providers work in low-resource environments. Therefore, any attempt to improve provider performance must consider how performance behaviors are influenced by the workplace context. The design of training must take into account contextual issues such as the presence or lack of performance factors in the workplace, the professional culture and cadre of health worker, the community culture (e.g., demographics, literacy, economics), and the country culture. These contextual factors combine to create a complex set of influences on behavior that will affect how learning is incorporated into a provider's performance.

Question 4. Describe how information technology has been used for training during the life of the PRIME project. What were the lessons learned?.

During the course of the PRIME II Project, training developers have responded to documented learning needs by identifying and using appropriate technology to close knowledge and skills gaps. PRIME has designed both low- and high-tech solutions that suit the needs of the learners in particular situations.

Many of the PRIME training interventions have blended approaches and methodologies to fit the environment and learners. Some interventions were based on low-tech solutions such as illustrated, highly structured print materials in a self-paced learning approach. Other interventions used higher-tech solutions including:

- ***Specially produced radio programming, radios and tape players*** to reinforce classroom and peer-based learning, share health messages and energize learning about reproductive health among members of isolated *batey* communities in the Dominican Republic. Health promoters conducted *charlas* (community discussion groups) in conjunction with radio broadcasts of "*En Familia*," an original radio drama series presented by professional actors. Promoters frequently replayed audiotapes of the programs for community members and for themselves, which reinforced the learning content in their promoter manuals. A community survey (baseline N=390 respondents, follow-up N=391 respondents) revealed that the percentage of community members who listened to programs about women's health on the radio remained high during the evaluation period (average 79.9%). The number of respondents who reported hearing about methods to prevent pregnancy during an episode of *En Familia* significantly improved between the baseline and follow-up measurements (74.8% to 82.8%, $p<0.01$).
  Lesson learned: Targeted health messages delivered during radio broadcasts and/or audiotapes of programs re-played during *charlas* can reinforce learning for both volunteer health promoters and community members.
- ***Cell phones*** to facilitate interaction between the promoters in the *bateyes* and the project facilitators. Community surveys and interviews with promoters during the baseline measurement indicated moderate use of cell phone technology by members of the *batey* communities. Training developers decided to use the existence of cell phones to test the feasibility of providing facilitator support to self-directed learning groups. Promoters with phones were provided with phone cards and instructed to call facilitators after their group meetings or whenever they had questions or concerns. During implementation, the cell phones proved inadequate to serve the needs of the promoters and facilitators; the connections in the *bateyes* were poor or the cell phones did not function. PRIME is optimistic that it might be possible to use this technology in the future. As demand increases, the infrastructure to support this technology will improve (for example, between baseline and follow-up a significant number of community members acquired cell phones: 21% of respondents at the outset, rising to 31.5%, $p<0.01$).
  Lesson learned: The technology did not function consistently enough to actually test this method of providing feedback to learners. As the technology infrastructure improves, cell phones may prove a viable method of providing support to learners. Future tests in other situations will help demonstrate and define the possibilities.
- ***DVDs and portable players*** to improve counseling skills of PAC providers in

Kenya. Monitoring data from learner follow-up visits revealed that the private midwives trained in PAC were not performing to standard in counseling PAC clients about family planning. To address this learning need, PRIME developed interactive simulations that run on portable, battery-powered DVD players. Midwives will participate and learn in virtual situations, gaining counseling skills without returning to the classroom for additional residential training. DVD technology provides opportunities for learners to see desired behavior modeled, make choices about what constitutes good behavior, and receive targeted feedback from a mentor based on their choices. PRIME has developed scripts for three simulations; the first has been videotaped and programmed, and will soon be pilot-tested in Kenya. The pilot-test will examine technology and learning issues such as the usability of DVD players, effectiveness of the simulations, and learner achievement using pre-/post- knowledge tests. Pilot test results will be used to make subsequent design decisions for the remaining scripts and provide information about the suitability of the technology.

Lesson learned: To be determined pending results of the pilot.

- ***PDAs (personal digital assistants)*** to collect and collate data, improving the ability of evaluators to monitor training interventions. Ready access to monitoring and evaluation data for analysis is essential for decision-making during program implementation. During the full implementation of the interactive simulation project in 2004, PRIME plans to equip data collectors with PDAs so they can record observation data during sessions with users and relay those files back to Chapel Hill for on-going analysis. We anticipate that this technology will reduce data entry errors significantly, eliminate labor costs for re-keying data from paper forms, and speed the analysis of data to allow more responsive decision-making during program implementation.

  Lesson learned: To be determined pending testing opportunity during project implementation.

- ***Internet and CDs*** for sharing information and publications about PRIME's training experiences. To improve access to our strategies, project implementation stories and lessons learned, PRIME has made key publications available on CD-ROM and on our web site [Transfer of Learning: A Guide to Strengthening the Performance of Health Care Providers (2002) and Performance Improvement, Stages, Steps and Tools (2002)]. The CD and web-based versions improve user access to information through interactive interfaces. Tools and support materials can be adapted for specific learning situations. User feedback about these materials continues to be very positive. For example, PRIME staff in Bangladesh who used the Transfer of Learning Guide during a workshop found it very convenient to support discussion by projecting the relevant frames from the CD. Learners reviewed the content in their printed Guides, highlighted important points and made notes.

  Lesson learned: As personal computers come into more widespread use in the countries where we work, providing technical resources electronically will become a viable, less costly alternative or supplement to printed materials.

Question 5. Describe how PRIME has established the capacity to develop training curricula; include countries, type of curriculum, and cadre of workers.

Building on a foundation established during PRIME I and predecessor projects, PRIME II has enhanced curriculum development capacity by working collaboratively with our counterparts in the field.

Typical design teams have included an instructional designer/trainer and/or content expert from PRIME headquarters, regional or country office staff working in conjunction with in-country curriculum developers, content experts, trainers, supervisors and learners. These teams have generally followed an instructional systems development (ISD) approach to designing an intervention. This approach involves:

1. Review of existing data on performance gaps
2. Identification of needs of the country and the particular cadre
3. Discussion of content
4. Development of methods and learning activities
5. Sharing of drafts of materials, refinements and improvements.

The following table provides some specific examples:

Examples listed here are illustrative, not exhaustive.

Country *Organization(s)*	***Cadre***	***Type of Curriculum*** *IST=In-service training; PST=Pre-service training*	***How capacity was developed***
Armenia Yerevan State Medical Institute	Primary care nurses Primary care providers family med. practitioners OB/GYNs and midwives Family medicine practitioners OB/GYNs and midwives at an outpatient primary care facility	IST infection prevention IST maternal and infant health IST/PST HIV/STI IST/PST RH in family medicine IST gender-based violence	To develop the training-related components of this project, PRIME created a "working group" that is engaged in the development and/or adaptation of all training curricula. Several training curricula are being or have been used in collaboration with the national training team, regional facilitators, staff at clinical training sites, primary care nurses and other primary care providers including family doctors, physicians and venerologists. Each module in a curriculum is reviewed and formally approved by the national MOH. In the family medicine program, one primary goal is to build

			capacity in curriculum development. PRIME is collaborating with a working group made up of faculty members and clinical providers in family medicine and obstetrics. This group is responsible for development of a learning needs assessment and the curriculum itself, and for implementing the training program. PRIME II is providing technical assistance, guidance and support. During the curriculum development phase of the nurse training program, a technical advisory committee was formed to assist in the creation and review of materials. PRIME staff developed five self-paced modules and corresponding training protocols with input from local staff.
Paraguay Quality and Maternal Health Projects MOH	MDs, nurses, TBAs, promoters	IST FP/RH, supportive supervision, infection prevention, safe mother-hood, PAC, COPE	PRIME II built capacity of local counterparts to develop and adapt several curricula to the local context. With partners, PRIME also designed FP/RH and postpartum/postabortion curricula, which are adaptable for a wide range of cadres. Local MOH technical staff and PRIME worked together to review national protocols and adapt curricula to local needs. PRIME II adapted EngenderHealth's interactive, digital infection prevention curriculum to train clinical providers. A supportive supervision curriculum, originally developed by EH and later adapted for PRIME II work in Honduras, was adapted for use in 23 health areas. In addition, PRIME worked extensively with the MOH to adapt and revise the

			COPE methodology already in use on the national level.
Uzbekistan Samarkand Medical Institute, Samarkand Medical College (Nursing), First Tashkent State Medical Institute, Second Tashkent State Medical Institute, National Refresher Training Institute, Andizhan State Medical Institute	General practitioners, OB/GYNs, perinatologists, nurses and midwives	PST/IST MCH/safe motherhood	PRIME II fostered curriculum development capacity by working closely with a skilled team of OB/GYNs, neonatologists, pediatricians and university professors with experience in curriculum design to develop a unique competency-based training program. PRIME developed and piloted a standardized, competency-based MCH training package for primary providers using existing safe motherhood reference materials from the WHO. The training package equips certified trainers with comprehensive, high-quality materials for training providers. A staff member from the WHO reviews and approves all curricula, while the MOH and the Board of Education provide oversight and approval of all activities and materials. The final package has been endorsed by the MOH for use in pre-/in-service settings. The materials are also being used by agencies in other countries within the region.
El Salvador SALSA MOH	MDs and nurses TBAs, promoters	IST FP and RH	The MOH developed capacity by involving all stakeholder groups in the development and review of curricula. PRIME secured support from high levels in the MOH for establishing the capacity to develop curricula. PRIME then identified MOH staff with the necessary skills and potential to be expert curriculum/training developers who could replicate the training model throughout a decentralized system. Curricula were developed to comply with WHO standards and were

			reviewed by local technical experts. Learner groups participated in the development of the curricula (e.g., parteras came up with the concepts for their training and rendered many drawings).
Ghana CHPS MOH	CHOs	IST Primary health care (FP and HIV/AIDS)	The Training Materials Working Group was formed with representation from the MOH, nursing schools, regions and districts. With PRIME's technical assistance, this group led the development of a 14-module training program for Community Health Officers (CHOs).
Ghana Ghana Registered Midwives Association (GRMA)	Private nurse-midwives	IST HIV/AIDS for adolescents	The GRMA team worked with PRIME I staff to develop a curriculum, including self-directed learning modules, for the pilot. The curriculum development capacity built during PRIME I enabled GRMA to independently revise the modules and develop a new module for the scale-up, with very limited technical assistance from PRIME II.
Rwanda MOH, various divisions, and ONAPO	A2 and A3 nurses working at health center level; regional health mgmt. teams	IST FP, safe motherhood, PMTCT, supervision	PRIME oriented a national team including representatives of the RH Division, Quality of Care Division, Nursing Division and ONAPO (National Population Office) on performance improvement based on tasks. The team developed clinical training curricula for A2 and A3 nurses working at health centers and supervision training curricula for regional health management team members, who are now able to review/develop curricula without external assistance.
Senegal MOH	Nurses and matrons	IST PAC	PRIME assisted a team of MOH trainers from the central and regional (Fatick) level and resource persons including nurses

			and matrons (for the identification of tasks) from the district (Sokone) level to adapt a curriculum for the training of nurses and matrons in PAC.
Benin MOH	Community health workers	IST FP/RH, HIV/AIDS	PRIME supported the MOH's IEC department in adapting the standard training curriculum in FP/RH/HIV/AIDS for CHWs.
Guinea SONUD	TBAs	IST safe motherhood	PRIME worked with Save the Children to support the MOH in developing a curriculum for training TBAs in safe motherhood.
Bangladesh NIPHP	Paramedicals, MDs	IST	PRIME staff guided the curriculum working group using a systematic curriculum development and revision process. The group included representatives from the service delivery partnerships and training organizations. Many of the training organizations are now developing their own curricula, using the process, format and tools supplied by PRIME.
Bangladesh HPSP Institute of Child and Maternal Health (ICMH), National Institute of Population and Child Health Training Institute (MCHTI), and Population Services Training Center (PSTC)	MDs, managers, supervisors, primary providers, and their immediate super-visors, trainers in lead training organizations(LTOs)	IST seven curricula (various topics)	PRIME assisted HPSP in adopting the national training standards to make the curriculum development process uniform, and in orienting training institutes and organizations on the standard curriculum development process. PRIME then guided efforts of sub-working groups to follow the process.

What were the lessons learned from trying to establish this capacity in the countries you work in?

- The establishment of capacity in curriculum development is best achieved through a participatory process involving high-level stakeholders, training developers, supervisors, content experts and learners. Involving key stakeholders and providing an appropriate level of technical assistance throughout the development process can lead to innovative approaches to curriculum design, curricula that are customized to the workplace context, and an increased commitment to make the changes necessary to implement a new curriculum.
- Early involvement of local training organizations in the curriculum development process enhances their ownership of training and increases their managerial capability to organize quality training.
- Frequent change in the membership of a curriculum development team affects the continuity of curriculum development and does not allow all team members to develop an equal level of skill in each step of the ISD process.
- Curricula must be linked with national training standards, protocols and best-practice guidelines.
- Norms and standards documents and existing training materials often do not address the needs of the community; this gap requires additional work for the curriculum design team.
- In a performance-based approach to curriculum design, identifying specific job-related tasks and writing appropriate learning objectives is the most difficult step in curriculum development. Performance-based approaches help developers recognize the significant impact of context and the need to design a structured plan for ensuring transfer of knowledge and skills to the workplace.
- Sometimes host-country counterparts are reluctant to engage in pre-testing and field-testing activities.
- Less structured curriculum/training development processes have resulted in curricula that contain content that is not essential for achieving desired performance and include activities that are not the most effective for learning new knowledge and skills. These processes have also failed to address all the factors that enable learners to apply new knowledge and skills on the job. In response to this situation, PRIME II has developed the Performance Learning Methodology (PLM), a systematic, analytical process that offers a practical way to identify the necessary content and most effective blend of approaches and methods for facilitating learning in the context of performance improvement. PRIME is field-testing the PLM and its tools during 2003-04.

Question 6. Describe the training sites established by PRIME, the status of the sites at this time, and what steps have been taken to assure their sustainability.

Training sites have a variety of needs depending on their mission, staffing, resources and structure. The table below describes how PRIME II has responded to a range of such needs to build site capacity and capabilities for improving primary health care training and learning services.

In addition to direct interventions at the training sites, PRIME works to ensure sustainability by:

- Assisting in the development of training standards and guidelines
- Collaborating with institutions and governments
- Advocating for institutional support
- Providing training to facilitate staff trainer development
- Offering performance improvement expertise and technical assistance to enhance and complement training and learning interventions.

Examples listed here are illustrative, not exhaustive.

Country *Project*	***Current status of training site(s)***	***PRIME's support for sustainability***
Bangladesh National Integrated Population and Health Program	The final project review found that six training organizations were still providing training and had substantially improved their institutional capacity for training.	PRIME provided technical assistance to develop training organizations' capacity to provide training in the Essential Services Package (ESP). Interventions included: • Enhancing the curriculum development capability of trainers • Installing trainer feedback mechanisms • Introducing trainer follow-up of trainees to observe and reinforce or correct new skills on the job • Strengthening trainers' clinical and training skills • Developing selected organizations' capabilities in alternative training approaches such as on-the-job orientation, distance-based learning and internship programs • Assisting organizations in strategic planning, business-plan development and marketing of their training services • Installing a training management information system (TMIS) and training organizations in its use • Monitoring training organizations' progress in training capacity development

Bangladesh Health Population Sector Program (HPSP) Six lead training orgs. (LTOs) and 460 training sites at sub-district level	All established training sites are being utilized for training: • 100% of ESP managers and trainers using national IST guidelines and checklists. • 100% (460) of sub-district training teams implementing supportive supervision • 100% (6) LTOs performing to national quality standards. • 88% of assessed training sites performing to national quality standards. • 45,000 primary care providers and their immediate supervisors trained in the 21-day Basic ESP Training Program	PRIME worked with the Government of Bangladesh to establish, monitor and support training sites for Lead Training Organizations (LTOs) and subdistrict-level in-service training. Training sites at LTOs were used for training trainers, while the subdistrict sites were used for conducting provider training. Steps taken to develop and sustain the LTO training sites included: • Developing guidelines and checklists for organizing training classroom and clinical practice sites • Mentoring training managers, coordinators and trainers of LTOs to establish and maintain standards of the training sites • Establishing a regular flow of information to TMIS for monitoring training quality and performance to standards • Strengthening coordination and collaboration between training institute and Technical Training Unit to make optimal use of LTO training facilities. Steps PRIME took to develop and sustain *upazila* (subdistrict) level training sites included: • Creating a team of trained trainers at each of the 460 *upazila* health complexes • Assisting with needs assessments and inventory of training sites • Developing guidelines and checklists for organizing training classroom and clinical practice sites • Designating a training coordinator to oversee the planning, management and evaluation of training • Assisting District Training Coordination Committees to oversee and support *upazila* sites • Establishing a regular flow of information to TMIS.
India Auxiliary Nurse Midwives (ANMs)	59 training sites strengthened to improve the quality of Auxiliary Nurse Midwives training. These training sites are being used continuously for initial and refresher training of ANMs. The sites are also being used for other training.	PRIME provided technical assistance to develop training sites for ANMs: Developing site selection criteria and tools With Regional Health and Family Welfare Training Center (RHFWTC) staff, assessing and selecting clinical training sites Developing list of training materials and other upgrades needed for selected classroom/clinical training sites and providing list to State Innovations in Family Planning Services Agency (SIFPSA) Training Dufferin Hospital master trainers and trainers of ANMs in use of the ANM clinic-based

		training curriculum Orienting RHFWTC data collection staff and continuously monitoring site upgrades Continuously monitoring and providing feedback to SIFPSA on the upgrading of training sites and the process and documenting of ANM training For the first time, the development of ANM training sites and the systems to support the training introduced an integrated skill-based training (as opposed to a classroom lecture method), with clinical practitioners side-by-side with ANMs'. Following the ANM training, SIFPSA has used the same structure to conduct refresher ANM training and training for community midwives.
India Community Midwives (CMWs)	Four Auxiliary Nurse-Midwives Training Centers are being strengthened to improve the quality of 18 months pre-service training for CMWs	PRIME has provided technical assistance to establish and assure sustainability of CMW training sites: • Developing site selection criteria and tools • Working with SIFPSA to select four districts (out of 13) where neglected training centers could be upgraded according to the selection criteria • Identifying necessary upgrades (to dormitories, kitchens, training rooms, links with clinical sites) for SIFPSA and the government of Uttar Pradesh to carry out at the training centers • Developing the 18-month curriculum, trainer's guide, participants' guide, clinical checklists and other materials for training CMWs • Training Dufferin Hospital master trainers who trained Lady Medical Officers (LMOs) in 13 districts (narrowed down to four) • Following-up the LMOs at their clinical sites (district hospitals) to mentor and improve their clinical skills • Training 16 ANM Tutors (four from each district) • Training Medical Officers at Primary Health Centers to provide field training for the CMW students in infectious diseases, etc.
India Community Partnerships for Safe Motherhood Shramik Bharti	According to the April 2003 evaluation, Village Health Workers (VHWs) trained by the NGO Shramik Bharti are still actively training community members in home-based life-saving	PRIME II assisted Shramik Bharti by: • Conducting a performance needs assessment • Collaborating with Shramik Bharti and community members to develop the home-based life-saving skills curriculum, Take Action Cards and other training materials • Training four master trainers, four community

(an NGO)	skills (the project ended in June 2002). Shramik Bharti is now providing training to other cadres of health workers as well.	facilitators, two field facilitators and providing technical assistance as Shramik Bharti trained Village Health Guides (VHGs) and community members • Strengthening Shramik Bharti's research capability, especially data collection and data entry • Training in gender sensitization and adult education • Assisting Shramik Bharti with community mobilization, orientation of VHGs to referral sites, preparing quarterly newsletter for communities and potential donors
Armenia	Training quality has been addressed and improved in four sites of the participating training institutions. These four sites are service delivery sites where clinical training practicums are now taking place.	PRIME II supported the following activities: • Obtaining national and marz-level MOH validation of the sites as clinical training sites • Providing basic training equipment such as mannequins and reference materials that can be used as part of future training programs • Selecting and training regional facilitators based in the clinical training sites as opposed to national trainers; in Armenia, this is the first time that regional trainers have played a role in training providers • Selecting trainers who have strong clinical skills, so that future training can shift from lecture-based to practical-based training. • Sharing widely the self-paced modules that can be used on their own to build clinical knowledge and practical skills. • Undertaking a series of activities to upgrade sites to serve as clinical training sites • Developing and introducing clinical training protocols • Training clinic staff and identifying clinical instructors • Providing basic equipment and training supplies.
El Salvador San Miguel and San Vicente Regional Hospitals	Training quality of the two lead training hospitals for the SALSA project has been improved. The hospitals are now implementing the clinical training functions.	PRIME provided technical assistance to establish the capability for curriculum development and clinical training in RH: • Providers were trained in clinical RH (PAC, VSC, IUD insertion) and training skills • The MOH chose the local hospitals as training sites to ensure sustainability and on-site training.
El Salvador	Established three train-	PRIME provided assistance in:

3 adolescent-friendly clinics (Sonsonate, Santa Ana, Usulutan)	ing sites for adolescent services. These sites are currently providing training for seven departments.	• Establishing youth-friendly services in hospitals located in departments with the highest rates of adolescent pregnancy by improving health providers' knowledge and skills to handle youth needs and concerns • Strengthening referral and counter-referral systems between hospitals and communities by establishing peer-to-peer networks that will help reach youth in distant communities and make them aware of contraception and of the importance of seeking care during a pregnancy and birth at one of the existing adolescent-friendly services sites.
Paraguay 1 MH training center	Designed and developed new MH training center; key national team of trainers completed all coursework and practicum; PAC training in process and equipment improvement in process	The Maternal Health Project in Paraguay is developing a model MH training center in the *Coronel* Oviedo Hospital in the *Caaguazu* District. Sixty physicians representing four hospitals and 11 health centers in *Caaguazu* were trained in Integrated Management of Pregnancy and Childbirth (as per WHO) through the *Centro Latinoamericano de Perinatologia* (CLAP) program in Uruguay. As part of the new national-level five-year RH plan, PRIME II is collaborating with the MOH on the development of new MH protocols. Currently, PRIME II is developing an agreement between WHO and CLAP that identifies equipment needed for the training center. PRIME II is also training 140 physicians in the PAC methodology. These providers are part of a national team related to the training center and referral hospitals.
Ghana MOH	Regional Resource Teams and their training sites have greatly increased their capacity to train and supervise providers within the integrated Safe Motherhood program	PRIME: • Equipped the regional training sites in Ghana's three northern regions • Improved the Regional Resource Teams' capacity for training • Strengthened safe motherhood supportive supervision including peer support • Oriented doctors to safe motherhood policies and standards
Mali MOPH	Trained teachers are a resource capacity. The schools are prepared for the next step—revising their curricula to incorporate FP and FGC	Over the last year, PRIME has assisted nursing schools/institutions (four public and one private-sector) to improve the quality of their training sites and centers by training teachers in management, supportive supervision, training methodology and FGC prevention activities.
Mali	Training for the PPH	PRIME helped establish eight health centers as

Postpartum Hemorrhage (PPH)	pilot project has been completed. The program will be continued and scaled-up under the new Mali bilateral	clinical training sites for active management of the third stage of labor (AMTSL) to prevent postpartum hemorrhage. PRIME interventions included: • Working with MOH technical resource persons to develop a PPH prevention training guide for AMTSL • Equipping the eight health centers with training materials and anatomical models/mannequins • Training 13 national trainers/supervisors and assisting them to train 107 providers in PPH prevention • Strengthening management and correct use of oxytocic drugs at ten sites in Bamako
Benin Postpartum Hemorrhage (PPH)	Training has recently been completed. Continued use of training sites and scale-up to new sites is awaiting finalization of evaluation report	PRIME established four training sites (two district and two regional hospitals) for training service providers in AMTSL to prevent PPH. PRIME's interventions included: • Assisting the MOH to adapt a training guide for AMTSL • Training two master trainers and 13 national trainers in AMTSL and training methodology • Assisting in the training of 105 service providers (Ob/Gyn and midwives) in AMTSL to prevent PPH.
Guinea Safe Motherhood	The site is now functioning without PRIME support	During 2002, PRIME prepared the hospital of Mandiana district and its maternity ward to serve as community life-saving skills training sites for service providers and TBAs and assisted in the adaptation of the curriculum and training of eight trainers.
Tanzania MOH	Training capacity and quality of Zonal Training Centers (ZTCs) has been increased	In an effort to build the capacity of staff in two zonal training centers, three skills development workshops were or will be carried out: • 20 ZTC and Reproductive and Child Health Section (RHCS) staff were trained in costing, pricing and marketing in June 2003 • 27 ZTC, RCHS and Regional Health Management Team staff were trained in quality and performance improvement in June/July 2003 • 20 ZTC staff will be trained in alternative education methods in September 2003. Following completion of the skills development workshops, PRIME II will assist the two ZTCs to complete their strategic plans, develop M&E plans and update their knowledge and skills in planning and management since this is one of the activities

		they undertake to build the capacity of Council Health Management Teams.
Kenya PAC	PAC training in Kenyatta Hospital has been completed for Phase II. Coast Provincial General Hospital gynecology ward is still being used as PAC practicum site for Phase III. All NGOs providing PAC use this facility.	During Phase II of the Kenya PAC project (2000-2002), PRIME helped prepare Kenyatta National Hospital as a PAC practicum site by providing clinical supplies (gloves, disinfectant). In Phase III (2003-2004), PRIME provided clinical supplies and trained four hospital staff who assist during training and ensure that the practicum and PAC clients are prepared.

What are the critical lessons you learned in making training sites sustainable?

- Building training site capacity and capabilities begins with securing institutional and/or government support and choosing sites based on appropriate selection criteria.
- Complete a Performance Needs Assessment (PNA), a critical first step in improving services. A PNA ensures identification of interventions needed to create a high-performance training organization.
- Assess trainers' knowledge and skills and provide the necessary training to close any gaps.
- Involve trainers in monitoring and evaluating training activities. Trainers who are also the supervisors of trained providers can support the providers at the worksite and facilitate the monitoring of training results.
- Develop the capacity of site managers to create, implement and monitor workplans and budgets, and conduct cost and financial analyses to ensure that training sites are operated in an efficient and financially responsible manner.
- Ensuring adequate client volume for clinical training practice remains a challenge that requires inventive solutions. In countries where a training site for a particular clinical service (and therefore client volume for training) does not yet exist, it may be necessary to send clinicians to neighboring regions or countries for training. For example, PRIME brought clinical providers from El Salvador to the Dominican Republic for training in postabortion care, IUD insertion and voluntary surgical contraception. Also, as observed in Kenya, it is anticipated that as training improves the ability of community-based providers to offer PAC services, client volume at regional PAC practicum sites will eventually be reduced to a level that necessitates a change in the training design.

Question 7. What linkages have been put in place for provider mentoring among professional schools, associations and service delivery sites?

Within the context of Performance Improvement, the PRIME II Project has successfully fostered many linkages among professional schools, associations and service delivery sites.

In addition to mentoring providers, these connections help to establish the framework through which providers understand job expectations and related performance standards. Professional associations work collaboratively with representatives from pre-service academic institutions, organizations responsible for in-service training, ministries of health and education, and cadres of health care workers. Helping PRIME's in-country partners to identify beneficial links among these potential stakeholders and then encouraging ongoing collaborative relationships has facilitated good use of limited resources and the development of sustainable systems. The examples in the table below summarize both linkages PRIME has established to support provider mentoring and linkages that support the broader agenda described above.

Country/Project	***Linkages***
East, Central and Southern African College of Nursing (ECSACON)	PRIME's collaboration with ECSACON has offered an opportunity to share experiences and build solidarity with members of professional associations across the entire East and Southern Africa (ESA) region. This collaboration is a perfect example of the broader agenda PRIME has achieved in fostering linkages among influential stakeholders. Part of ECSACONs mission is to improve the quality of health care in ESA through implementation of their Harmonization Initiative, which established professional practice standards and minimum education/curriculum requirements for nurses and midwives. PRIME facilitated this effort with ongoing technical assistance during development of the Nursing and Midwifery Professional Regulatory Framework. PRIME also provided assistance with development of an advocacy materials kit, financial support for advocacy skills training, and creation of a job aid to help country representatives adapt and implement the regional regulatory standards in their own countries. The experiences of the country representatives from Zambia exemplify the significant impact of PRIME's support to ECSACON: • Advocacy training for the core team helped identify and mobilize the necessary in-country resources • Facilitation and mentoring by the core team increased advocacy by nurses and midwives for policy changes to expand their role in addressing the health challenges of the 21st century • Nurses and midwives organized to champion for national policy changes in a politically unstable environment • The Nurses Act expanded the roles of nurses and midwives • ECSACON's Regulatory Framework was adapted for Zambia

	• Multiple academic programs were harmonized through curricula revisions and consolidations • FP/RH Performance Standards and Practice Guidelines were strengthened by including consumer perspectives • Standards and guidelines will be institutionalized into pre-service and in-service nursing education and training programs as well as service delivery. In addition to the linkages ECSACON has built among the 14 member countries and within each country, the organization has fostered collaborative relationships with WHO and the International Council of Nurses (ICN). WHO and ICN paid great tribute to the Framework and the technical assistance efforts of PRIME/Nairobi at the ECSACON conference in August 2002.
Kenya PAC Scale-up	The ongoing efforts of the National Nurses Council of Kenya (NNAK) played a key role in establishing support for PAC services among nurses and midwives. The NNAK has 30,000 members; many keep abreast of the latest information about PAC services through attendance at national and regional association meetings and through the NNAK professional journal. NNAK's consultative status with the Nursing Council of Kenya and the Nursing Division of the Ministry of Health helped promote the adoption of high standards of practice and ethics among providers offering PAC services.
Ethiopia Safe Motherhood	PRIME facilitated collaboration among the Ethiopian Midwives Association (EMA), the National Society of OB/GYNs (ESOG) and the Family Health Department of the MOH to develop joint standards for cadres providing safe motherhood services. As a result, the cadres regulated by these organizations provide standardized maternal and child health care, emergency obstetric care, and labor and delivery care.
Bangladesh Health and Population Sector Program (HPSP)	The Technical Training Unit (TTU) of the Ministry of Public Health linked with six lead training organizations, 64 District Training Coordina-tion Committees, 460 Upazila Training Teams, 20 Regional Training Centers and 12 Family Welfare Visitor Training Institutes. TTU also established a pre-service linkage with an undergraduate medical college through the Medical Education for Essential Health Services Project of DFID and provided inputs to develop Essential Services Package curricula to train doctors in five constituent upazila health complexes. Primary providers and immediate supervisors received training together to facilitate support at worksites. Immediate supervisors also received supportive supervision training to help improve provider performance.
Bangladesh NIPHP	Through the selection and strengthening of the Obstetrics and Gynecology Society of Bangladesh (OGSB) as a National Integrated Population and Health Program (NIPHP) training organization, PRIME helped establish linkages between the OGSB and NGO clinical sites. OGSB provided training in safe delivery and other reproductive health care as well as follow-up and mentoring of trainees.

India CMW Training	Linkages have been established between auxiliary nurse-midwife training centers (ANMTCs) where community midwives (CMWs) receive pre-service training and District Women's Hospitals for clinical practice by ANMTC trainers and CMW trainees.
India ANM Training	Service sites with trained auxiliary nurse-midwives (ANMs) are linked with Regional Health and Family Welfare Training Centers for follow-up and assessment of the on-the-job performance of trained ANMs.
Armenia Family Medicine	Armenian Medical University, FHI (Armenian in-service institution) and members of the family medicine association are participating in a working group to develop the RH component of the family medicine curriculum.
Armenia Nurse's Training	Linkages have been established among national and regional nursing schools to train health post nurses. Although there is no formal association, national and regional trainers form a loose collective that provides ongoing support to trainees and linkages with other organizations through their professional affiliations (e.g., MOH, pre-service institutions, health care facilities).
Dominican Republic Medical Curriculum	A memorandum of understanding has established linkages among a major hospital (the Maternidad Nuestra Senora de la Altagracia), the national ob/gyn society and three medical universities. Agreements include a working group to review and update the medical curriculum, implementing revisions, training professors in participatory methodology and evidence-based practices, and monitoring students in their clinical rotation. This linkage took PRIME three years to develop and will be continued by FHI through the new five-year bilateral.
Mali FGC	The Reproductive Health Division of the MOH and the Secondary Health School are linked to conduct training of RH providers. Trainers from the school were involved in development of the female genital cutting (FGC) resource package and trained in its use.
Mali Safe Motherhood	The MOH/Planning Training and Information Unit teamed with the Association to Support Population and Development Activities (ASDAP) to pilot-test Training Information System software. This software is intended to create a training database that will help the MOH report, on an ongoing basis, updated information on training received and needed by providers.
Mali	Through PRIME's support, a linkage exists among pre-service training institutions (Secondary Health School, Ecole Privee de Sante Les Bouctou) and service delivery sites for the practical training of students in nursing and midwifery. Tutors work with preceptors to develop training objectives and mentor the students at practicum sites.
Ghana GRMA	PRIME helped establish a link between the Ghana Registered Midwives Association (GRMA) and private maternities through GRMA's self-directed learning program for improving adolescent RH client-provider interaction skills for private midwives.

Question 8. Describe how PRIME has improved management support systems. Provide case examples.

Primary providers who have benefited from strengthened pre- and in-service training and continuing education systems also need effective managerial and supervisory support on-the-job to sustain good performance. In the majority of the Performance Improvement projects implemented thus far, PRIME has improved the supportive environment for providers by analyzing needs and then strengthening existing systems and/or designing practical systems to address specific problems in the context of particular countries.

The systems PRIME works to improve are often embodied by supervisors who have the potential to offer much of the management support providers need. In several PRIME II projects, training interventions have fostered improved support by linking supervision and training systems. In Kebemer district, Senegal, for example, clinical supervisors helped to prepare and conduct training for the community-based family planning providers they oversee, setting the stage for continued post-training coaching and follow-up to maintain and enhance performance. After conducting an assessment using the PI approach, PRIME also trained the supervisors in supportive supervision techniques and introduced ten supervisory tools. By discussing performance expectations and offering regular feedback and encouragement, the supervisors were able to more effectively coach the newly-trained providers, which, in turn, allowed community-based distribution agents to better meet their goals.

In Uttar Pradesh, India, PRIME assisted in training more than 1,000 Lady Health Visitors in supportive supervision as part of in-service training in clinic-based family planning services that they attended with their supervisees, Auxiliary Nurse-Midwives. Results indicate that the Lady Health Visitors' supervisory practices improved and helped 88% of the more than 9,500 Auxiliary Nurse-Midwives maintain acceptable post-training performance levels. Notably, such supervisors often play an extremely important role as a link between providers, their clients and the communities they serve. In both Senegal and India, the trained supervisors helped boost the providers' standing in their communities. PRIME II supervision-related projects with anticipated results similar to those from Senegal and India are ongoing in Benin, Ghana, Honduras, Rwanda, Armenia and Kyrgyzstan.

Where relying solely on formal supervision presents challenges, PRIME has introduced peer-group approaches to help form a supportive environment for providers. In Honduras, for example, lack of time and resources limits clinical supervisors from making frequent visits to the family planning sites they supervise. Even though the supervisors' have increased their skills through training in supportive supervision, providers still need more regular support to maintain good performance. In this case, PRIME helped train peers to support one another with feedback, coaching and mentoring. A similar situation presented the impetus for an ongoing peer support project among private nurse-midwives providing family planning and postabortion care services in Kenya. PRIME II has also used peer

support as an adjunct to regular supervision for community health promoters in the Dominican Republic.

Other sources of support PRIME has used to strengthen management support systems include:

Consumer Input and Feedback

- Clients set performance expectations (Nicaragua and Benin)
- Clients' evaluations serve as performance motivation for providers (Kyrgyzstan)
- Providers receive face-to-face performance feedback from consumers (Paraguay)
- Potential clients (consumers in the community) provide clear expectations of types and quality of services they would like to receive (multiple countries)

Enabling Work Environment

- Assisted in the establishment of an inexpensive clean water system for hand-washing at rural clinics without running water (Paraguay)
- Adapted materials to support essential performance training messages for providers (El Salvador)
- Assisted in the development of clear normative expectations for emergency obstetric care (Nicaragua).

Question 9. What approaches has PRIME used to monitor and evaluate the effect of training on provider performance?

Consistent with the need to evaluate not only the acquisition of knowledge and skills by trained providers but also the effective transfer and application of learning in the work environment, PRIME II has adopted an expanded monitoring and evaluation (M&E) model that goes beyond training-only effects and examines provider performance at the service delivery point (SDP).

The expanded model has allowed collection of data to report on "number and percentage of providers performing to standard," PRIME Performance Monitoring Plan (PMP) indicator #1, and the indicator most central to the Project. The model integrates the PI framework and emphasizes a shift from assessing outputs to evaluating the effects (and impact, whenever possible) of training (see graphic below). Methodologies and instruments have been developed or adapted correspondingly; for example, knowledge tests self-applied during classroom training have been supplemented by direct observation of actual performance at the SDP.

Before interventions, desired performance and standards are defined by stakeholders, typically during a performance needs assessment (see IR1, Question 2). Evaluators use observation checklists of individual performance items that capture the range of skills and tasks providers are expected to accomplish. The evaluator can analyze items separately to identify areas of weakness or derive composite indices summarizing the average performance of providers. Actual performance is then compared to desired performance to arrive at the performance gap(s) to be reduced or eliminated through selected intervention(s). PRIME has made a special effort to conduct baseline assessments for every intervention, and is continually collecting information on critical changes occurring in provider performance as a result of training and other support interventions.

PRIME also assesses the effect of training and non-training interventions at the SDP level by examining changes in client outcomes as they appear in client records and statistics. Increased numbers of clients or percentages of adolescents or men attending a clinic, for example, offer another way of assessing provider performance (and gauging client access to services). Similarly, data collectors gather information on the non-training factors affecting performance. For example, health inventories document the equipment and supplies situation at a clinic. Interviews with providers may reveal deficiencies in job expectations, motivation, feedback, supervision and so on. In addition, PRIME has consistently gathered information on client satisfaction through client exit interviews, and incorporated consumer input to improve quality of care through focus group discussions among community members and health care representatives. Other indicators to fulfill PRIME II PMP requirements include "number of training sites and centers performing to quality standards" (Key PMP #3) and "national standards, guidelines and protocols created, updated and applied at facilities post-dissemination" (Key PMP #7). These and other indicators (including the ten key PMP indicators) have been widely standardized across projects and interventions.

How has PRIME used the evaluation results?

Baseline measurement has been critical to ascertain performance gaps. By analyzing individual performance items stakeholders are able to identify specific areas of intervention (e.g., counseling vs. clinical) to be strengthened as opposed to adopting a "blanket" training approach. Of course, baseline measurements also provide the necessary foundation for assessing changes when compared with similar measures of performance after the intervention (see examples in TLA Question). In this way, PRIME has demonstrated performance improvement as well as reduction in performance gaps. When applied during the life of a project, performance evaluations have also helped managers monitor project progress and identify areas where more effort is required (e.g., the January 2003 mid-term evaluation in Paraguay). Results have been used to reinforce good performance and have served as a positive incentive to maintain improved behaviors.

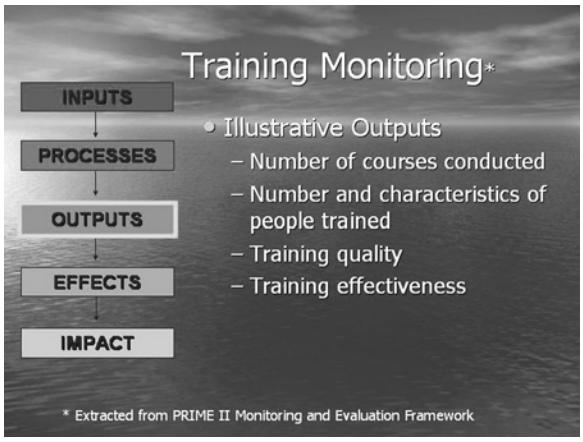
What were the lessons learned about evaluating performance?

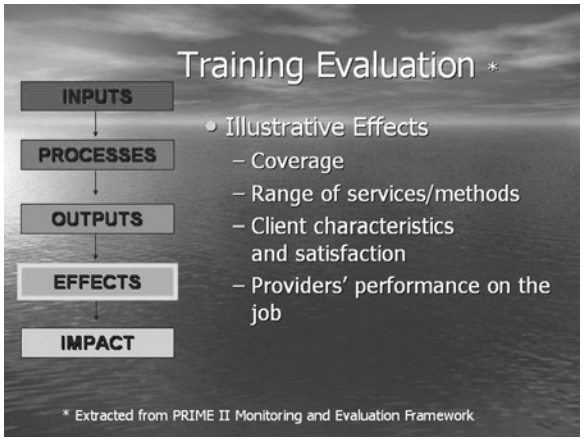
PRIME has found that moving away from pre- and post-tests at the classroom level and into facility-based measurement, while creating more challenges and constraints in design and field work, better serves clients and counterparts by determining with added certainty the results of training and supporting primary providers. The development of tools and techniques for provider observations, client interviews and analysis of service statistics has furnished PRIME with a wide arsenal of approaches to help answer the "so what" question regarding the effects of interventions on provider and clinic performance.

An example of the challenge in designing appropriate tools for measurement comes from Bangladesh, where project staff designed a baseline assessment for two different cadres of paramedics (one delivering mostly child health and the other reproductive health services) whose performance was to be integrated through the intervention. Because of the differing range of skills, the tasks were observed through a standard checklist; items were kept too general (e.g., courtesy to clients, confidentiality) and did not capture the most important aspects of "performance." While this situation was difficult to resolve, we now believe the designers should have included the distinct clinical components in the checklists, assessing how integrated they had become after the intervention.

A second lesson learned derives from the need to streamline the concept of performance to reflect what an intervention sets out to accomplish. PRIME has applied "templates" of performance to areas where an intervention addressed a subset of skills and tasks. In such cases it would have been advisable (and probably more cost-effective) to have measured performance only for those areas of intervention rather than on the full range of possible tasks. As PRIME strives to use essential learning methodologies, we can also develop "essential evaluation" methods and instruments for more efficient M&E.

PRIME has also learned that to progress from measuring outputs to effects, the M&E designs require investing more time and resources. Though this has generally been accomplished, there have been occasions when missions and counterparts have had differing priorities, making PRIME's mandate of reporting results quite challenging. IntraHealth anticipates that continued emphasis on results will support proper monitoring and evaluation of all projects.


Training Monitoring*
INPUTS
PROCESSES
OUTPUTS
EFFECTS
IMPACT
• Illustrative Outputs
– Number of courses conducted
– Number and characteristics of people trained
– Training quality
– Training effectiveness
* Extracted from PRIME II Monitoring and Evaluation Framework


Training Evaluation *
INPUTS
PROCESSES
OUTPUTS
EFFECTS
IMPACT
• Illustrative Effects
– Coverage
– Range of services/methods
– Client characteristics and satisfaction
– Providers' performance on the job
* Extracted from PRIME II Monitoring and Evaluation Framework

Question 1. Describe how performance improvement methods have been used to address management support in health care service delivery systems.

The PRIME has applied Performance Improvement methods to address management support by focusing on what providers need to perform to standard and analyzing "up" the organization to determine the best sources of such support. In collaboration with stakeholder groups, this process typically follows the following steps:

- Understand the overall RH care system goals for the country, region and district in which the providers work
- Align provider goals and desired performance with overall system goals; describe desired provider performance
- Assess current performance
- Determine the root causes of gaps between desired and actual performance (or, in the case of new performance, the performance factors needed to support providers)
- Examine the health care system to determine the best source(s) of management support.
- As soon as the types of needed support have been spelled out, PRIME carefully examines available support systems. After clearly cross-referencing the needs with available systems, the configuration of management support PRIME can bring to bear becomes clearer.

Describe Results and Lessons Learned.

A good example of PRIME's work in this area is the Safe Motherhood (SM) provider system in Ghana. After aligning provider goals with the overall goals of the SM system, PRIME found that providers generally had good training in SM skills. However, the providers needed supervision for feedback, coaching, and encouragement and motivation when using new skills. In turn, PRIME examined the supervision system and discovered that the supervisors themselves needed management support in order to help the providers. The supervisors, Regional Resource Team members (RRTs), lacked even a single individual in the health care system to whom they could turn with questions or other needs. After basic supervisory training they were left on their own to do the best they could. PRIME arranged for RRTs to become integrated into the regional RH system and supervised and supported by Regional Directors, who helped set performance goals, offered feedback and encouraged RRTs in their supervision duties. Taking advantage of their new place in the system, more RRTs significantly increased supervisory visits to SM providers (from 40% to 67%), and their supervision visits satisfied almost all SM providers. PRIME expects provider performance on SM tasks will have increased substantially by the time the final evaluation is conducted by the Population Council in October 2003.

What have been the challenges using this methodology?

The most important lesson PRIME has learned about management support systems is that even when we start with primary providers as a unit of analysis, we must address

management systems at several levels of the organization. In the words of a PI specialist from East Africa "it's hard to know where to stop!" As in the Ghana example above, supervisors of providers often lack management support themselves. While it is impossible with limited funding to repair the management of an entire national health care system, we must examine several levels in order to ensure providers get the support they need. In response to this challenge, PRIME has teamed up with MSH's Management and Leadership (M&L) project to simultaneously address primary provider supervision systems (PRIME) and the human resources system in the Ministry of Health (M&L) in Armenia. The resulting improvements should be both responsive to providers and sustainable as part of the overall human resources system.

Question 1. In what countries has PRIME improved national standards, guidelines, norms and protocols for service delivery and preservice education?

PRIME has been involved in three categories of standards and guidelines to improve provider performance:

- **Updating national protocols**
- **Integrating new components into existing protocols**
- **Developing training protocols and job descriptions/performance expectations based on updated national RH protocols.**

These efforts ensure that curricula developed for training activities rely on the latest evidence-based interventions.

Updating National Protocols

In more than a dozen countries from five global regions, PRIME assisted in writing or updating national standards. The Project examined existing standards, reviewed country needs, and responded with appropriate technical assistance based on our experience with policy and guidance affecting primary providers' ability to offer quality services.

- In Bangladesh, PRIME was a key player in developing and disseminating new national training standards, guidelines and checklists for in-service training.
- In Benin, family planning/reproductive health guidelines were updated with extensive PRIME involvement and are now being disseminated after two full reviews and field tests for five levels of care; emergency obstetric and neonatal care protocols were also written and disseminated. PRIME has taken advantage of the dissemination process to update providers' knowledge and skills.
- In El Salvador's SALSA Project, PRIME helped revise and disseminate norms for family planning, cervical cancer and safe motherhood, and encouraged their use by primary providers in various PI interventions.
- In Honduras, a PRIME-supported effort validated guidelines for licensing facilities and improving provider performance.
- In Nicaragua, PRIME participated in the national commission charged with developing emergency obstetric care service protocols, contributing expertise in service delivery at the primary level.
- In Paraguay, PRIME reviewed and updated IUD protocols, which are now included in clinical in-service training.
- In Rwanda, PRIME spearheaded a national reproductive health policy effort; the policy was recently signed by the Rwandan Minister of Health and will be disseminated nationally in the fall of 2003. With assistance from PRIME the Ministry of Health is writing new RH guidelines for application of this policy.
- In Tanzania, PRIME worked in a consortium to update national standards for FP and safe motherhood; the Project also worked through the Quality Improvement Recognition Initiative project to update standards for in-service training in tuberculosis, HIV/AIDS and malaria.

Integrating New Components into Existing Protocols

In Armenia, Benin, Ethiopia, Mali and Tanzania, PRIME has assisted efforts to broaden national protocols to include one or more new components in:

- STIs and HIV/AIDS
- Gender-based violence (GBV)
- Female genital cutting (FGC)
- Active management of the third stage of labor (AMTSL).

As part of the Francophone MAQ initiative, PRIME worked to integrate HIV and STI information into the new RH protocols. PRIME-led efforts are creating protocols for the recognition and treatment of GBV in Armenia. In Tanzania, PRIME's efforts led to the integration of STI screening into updated national standards for family planning and safe motherhood. PRIME's work in Mali supported development of guidelines for providers that help them discourage FGC practices. In the three countries where PRIME was chosen to participate in the USAID special initiative for prevention of postpartum hemorrhage (Benin, Mali and Ethiopia), the Project has worked to integrate AMTSL standards into the national practice standards.

Developing Training Protocols and Job Descriptions/ Performance Expectations Based on Updated National RH Protocols

Many PRIME country programs have identified a training component related to updated RH protocols, working through this avenue to improve provider performance. When possible, PRIME develops training protocols based on updated national RH protocols. The training protocols then serve as the basis of curriculum development for in-service and pre-service training, training new cadres of primary providers and expanding the roles of established cadres.

- In Armenia, training protocols were developed, approved and utilized to expand the role of nurses and midwives serving in 60 FAPS (village health posts).
- In Benin, the development of national family health protocols was an ongoing and participatory process, involving the ministry of health, trainers and primary providers.
- Working with ECSACON (East, Central and Southern Africa College of Nursing) PRIME helped update regional training and practice standards to harmonize curricula throughout the region.
- In the Ghana Safe Motherhood program, PRIME helped develop training protocols that are now being used as a basis for revising the national standards in safe motherhood.
- In Uzbekistan, the PRIME-supported competency-based learning package for normal delivery has been set as the national training standards for primary providers.

To what extent are these documents being used today?

In Benin, PRIME facilitated the effective introduction of new protocols by linking with training in protocol applications. The program minimized disruption of services by training providers in the protocols at their service delivery sites through an approach that combines a short classroom orientation with tutorials and self-directed learning. By training providers at their workplaces, this approach allows for site-specific problems to be addressed directly using the protocols. A six-month follow-up of providers participating in the tutorial approach showed

that the protocols had been consulted by 95% of the providers subsequent to training, and more than half reported using them often; 94% of the providers were able to identify appropriate protocols and describe the process of care when given a case example. Also in Benin, PRIME worked with trainers throughout the country, updating them in the use of the national EONC training guide. This core group, in turn, is training RH service providers throughout the country in an ongoing effort.

In Honduras, a group of 25 facilitators were trained as inspectors to implement the facility licensing process throughout the entire country. The facilitators are using the manuals and checklists created in the PRIME II intervention area, Olancho. Their inspection process will continue regularly at the national level, ensuring that all health facilities meet minimum requirements.

Experts from PRIME and the ministry of health are working together in Paraguay to update, review and validate RH protocols for all levels of care. They will present their findings to the ministry, and incorporate them into the new five-year national RH policy.

PRIME also participated in the development of WHO/Geneva family planning protocols, which are in use globally:

- *Medical Eligibility Criteria for Contraceptive Use*, second edition (2000)
- *Selected Practice Recommendations for Contraceptive Use* (2002).

What are the lessons learned about protocol development?

Across all the countries where PRIME II has worked to develop protocols, the most important lesson is that the work does not end when the protocols are developed, reviewed and printed. Effective dissemination strategies and attention to links between the protocols and actual provider performance are essential. Gaps in the "clear expectations" performance factor are frequently associated with providers who have not sufficiently internalized national standards, guidelines and protocols. Providers, in concert with their supervisors or mentors, make progress when their performance expectations are based on the contents of the protocol documents and influenced by their own individual priorities.

Because developing national protocols is a difficult process, they tend to remain static rather than dynamic and responsive to the changing needs of providers on the front lines of health care. Our work in Benin shows that protocols can be updated regularly to excellent effect. The key to this success is a motivated working group gathered at planned intervals under the auspices of the ministry of health.

In Armenia, Uzbekistan and Ghana, PRIME found that training protocols based on national RH protocols take less time to develop. These training protocols ensure that curricula are based on state-of-the-art knowledge, and make the national protocols more useful and dynamic. In Ghana, the training protocols reached even further, serving to guide development of new national RH protocols.

Question 2. How has PRIME improved policy development, dissemination and implementation? Provide case examples.

PRIME's work in policy has focused on service policy formulation and efforts to create policy environments that are more favorable to the delivery of services by primary providers who are not always part of the formal health structure.

Realizing that the existence of clearly stated FP/RH service policy is a powerful facilitating factor and a prerequisite for both performance improvement and training, PRIME has often begun its work by helping beneficiary countries and institutions develop national service policy and protocols. In several countries, the ministry of health leadership has recognized our preeminence in performance improvement, which specifies a supportive policy environment as a critical performance factor. At the request of select ministries, PRIME has worked intensively on the development of national policies in reproductive health.

During this process PRIME brings the PI approach to bear, so that changes in the policy environment will significantly enhance service delivery and accessibility. We collaborate with ministries of health to revise existing policy or create policies that are missing. When the updated policy has been reviewed, revised and signed, empowering providers and clients and maximizing quality of services, PRIME moves forward with interventions indicated by performance needs assessments.

Case Examples of Policy Development, Dissemination and Implementation

Armenia

Early in our work with the Armenian Ministry of Health, PRIME organized a policy working group that prioritized elements within each reproductive health component (e.g., prenatal care, intrapartum, postpartum/newborn, STI prevention, family planning). With this systematic approach, we were able to define the roles and responsibilities of RH providers at all levels of the health delivery system. A policy document, while not yet officially adopted, serves as a guide for further policy work and a foundation for PRIME's interventions, expanding the role of nurses and midwives working at the most primary levels of care. PRIME has continued to promote policy dialogue regarding the role of primary care providers, enabling them to meet the needs of hard-to-reach clients in rural areas.

PRIME then organized a national forum, in which RH stakeholders reached consensus on actions needed to improve accessibility and quality of reproductive and child health services. Over 100 national and international experts came together in Armenia to discuss major issues and gaps in reproductive and child health services along with recommendations based on WHO guidelines. Since the national forum, the MOH has relied on continued technical input from PRIME in drafting RH legislation. The resulting legislation, recently passed, articulates a broad range of reproductive rights, including access to contraception, health education for youth and freedom from sexual coercion. The MOH also drew on the national forum report to draft the national health policy for 2004-2009. This policy addresses the critical interventions needed to expand access to primary health care.

Rwanda

As the basis for preparing new national reproductive health policy, standards, guidelines and protocols in post-genocide Rwanda, the Ministry of Health asked the PRIME Project to draft the first national policy on reproductive health since the 1994 war. To identify the reproductive health priorities for the country, PRIME organized a roundtable conference in September 2000. The Project then launched a collaborative process with the ministry and all partners involved in reproductive health to develop the draft policy, which was provided to the Ministry in June 2002. After delays due to competing political priorities and changes in key leadership at the Ministry, the policy was signed in July 2003, and will be disseminated nationally.

Ghana

In the Community-Based Health Planning and Services (CHPS) initiative, PRIME has worked closely with the Ministry of Health, which adopted CHPS as the national strategy for increasing access to primary health care. PRIME's first role was to identify the service package to be delivered by a new community-based cadre, the Community Health Officer (CHO). After delineating the services CHOs will offer, PRIME developed an orientation curriculum and learner support framework. PRIME has collaborated with JHPIEGO, JHU/PCS, the Population Council and EngenderHealth to implement and expand CHPS in 28 districts. The Project has focused on preparing and deploying the CHOs (training 160 CHOs and 80 supervisors to date), and strengthening community-provider partnerships. PRIME has also assisted the MOH with:

- A Lead District Readiness Assessment of 20 districts (an adapted PNA)
- A CHPS District Cost Analysis, to provide planning information to national, regional and district leaders that will help guide their scale-up plans.

Paraguay

In Paraguay, PRIME designed and implemented an evaluation of the Ministry of Health's five-year national RH policy. The Project followed a comprehensive evaluation methodology that included a myriad of stakeholder interviews, all the way from high-level government officials to clients in rural areas. The evaluation team observed providers at health facilities and conducted 20 focus groups. The results revealed a particular weakness in dissemination of reproductive health information. Currently PRIME is assisting the MOH in the design of a RH/sexual health plan that will be used as the new policy for 2003-2008. The participatory design process includes local stakeholder workshops in all seventeen geographical departments of the country. Once the new plan is in place, PRIME will be responsible for training and disseminating the policy throughout the country.

Question 3. How has PRIME assured informed choice within their family planning and reproductive health projects?

PRIME has emphasized informed choice at all levels of its many activities to improve family planning and reproductive health (FP/RH) care including policy development; national protocols, guidelines, standards and job aids; training curricula; and supervision systems.

Policy and Implementation of Policy

Informed choice has been a guiding principle during PRIME's assistance in developing national reproductive health policy in Armenia, Paraguay and Rwanda (see IR3, Question 1).

Protocols, Guidelines, Standards

In more than 15 countries, PRIME has updated RH protocols, guidelines and standards for doctors, nurses, nurse-midwives and community providers. These activities have focused on family planning, STIs/HIV/AIDS, PMTCT, postabortion care, emergency obstetric and neonatal care, breastfeeding and prevention of postpartum hemorrhage. Throughout, systematic counseling for informed choice has been emphasized for women and couples making FP/RH decisions. For example:

- **Tanzania:** PRIME helped develop standards ensuring that RH services will be provided to any woman, man, couple or adolescent regardless of age, parity, marital status, race or sexual preference; standards for Safe Motherhood ensure that women are given choices about pain control and positions for labor and giving birth.
- **El Salvador, India:** PRIME assisted with the expansion of method mix for greater informed choice by introducing FP as a service to be offered independently by community health care providers.

To support informed choice, PRIME has created job aids for providers and supervisors, teaching aids for tutors and trainers, and educational materials for clients and communities. One example now in use throughout the world is the poster on family planning methods developed with JHU, USAID and WHO, which includes a section on self-assessment of conditions for selection of a FP method. PRIME also played a role in the development of the WHO/IPPF client-provider desk flipchart.

Training

As a general rule, PRIME training curricula address all FP methods available in a country, and cover RH decision-making and skills in client-provider interaction. Module One of PRIME's Reproductive Health Training for Primary Providers: A SourceBook, widely used by RH training curricula developers, explains how to counsel clients to make informed choices for FP/RH decisions. Examples of PRIME's efforts to promote and ensure informed choice through training include:

- **Benin, Nicaragua:** PRIME trained pharmacists and their staff in informed choice and the need to counsel clients about all FP methods, including emergency contraception, and

condom use for STI/HIV prevention.

- **Armenia:** PRIME has been able to effectively transition village health care providers from a rigid, hierarchical Soviet style
- **El Salvador:** PRIME developed pictographs to work with low-literacy providers and clients on FP counseling and methods.
- **Paraguay:** PRIME collaborated with EngenderHealth to update PRIME trainers in informed consent and informed choice. PRIME then trained all staff in the 23 facilities where the Project is working and developed job aids and a poster on client rights to ensure appropriate counseling. All clients sign a sheet indicating that they received counseling prior to choosing contraceptives.

Systems Approach

Policy, protocols, training and supervision are sometimes not enough to ensure informed choice. Whenever possible, PRIME also offers assistance at the systems level to make available the equipment, supplies and drugs that enable providers to deliver services with informed choice. These efforts include:

- **El Salvador:** PRIME has assisted in developing and implementing an automated contraceptive logistics system on the national level. Through this system, trained MOH personnel can now inventory supplies, analyze needs and calculate projections based on those needs to ensure better method availability in health facilities and among promoters working at the community level.
- **Dominican Republic:** To increase the access of community members to FP methods and information supplied by trained volunteer health promoters, PRIME created a rotating fund managed by the implementing NGO, IDAC.
- PRIME has worked with **UNFPA** in many countries to ensure adequate supplies of contraceptives are available.

Question 1. What strategies has PRIME implemented to inform and empower clients and communities? Describe the results of these strategies on access to care and health care quality.

The PRIME II Project has shown clearly that when client populations are fully informed about their health care rights and service options, they are able to best access and use services. PRIME has promoted Integration of Consumer Perspectives (ICP) within its programs (formerly as Consumer-Driven Quality), developing tools and strategies that allow providers to leverage critical consumer input. Giving providers a better understanding of the needs of their clients and potential clients, these strategies can transform deeply ingrained beliefs about how providers treat clients, make care decisions and structure their work.

Bringing services closer to the consumer

With encouragement from PRIME programs, providers get out of their clinics and into the community, providing educational sessions for consumers wherever they congregate—churches, schools and social events. PRIME programs also follow consumer patterns to find the appropriate primary providers to meet service delivery needs. In Nicaragua, for example, youth often rely on pharmacies for health care advice, products and services. PRIME facilitated partnerships between youth organizations and pharmacies that offer feedback to pharmacists to help them understand how well they are meeting youths' expectations and needs.

Speak the consumers' language; listen to the consumers' needs

In many PRIME projects, providers engage in dialogue with local consumer leaders and share their outreach to the community. PRIME tools have been specifically developed or adapted to gather meaningful input from consumers in Nicaragua, Uganda, Zambia, Rwanda and the Dominican Republic.

Involve consumers in decision-making processes

PRIME supports providers' efforts to develop consumer quality committees. In the Dominican Republic, these committee meetings generated ideas for community *charlas*, talks on reproductive health care given by providers in the community, and for tools to receive consumer opinions during clinic promoter home visits. In Zambia, PRIME demonstrated that consumers can have effective input into service delivery norms for providers.

Select changes or interventions that allow the clients to own, act on, and see the changes resulting from their input.

PRIME and cooperating NGOs invite consumers to the providers' clinics to gather feedback; then, when changes based on that feedback have been implemented, they invite the consumers to return to the clinics and witness the impact of the changes that were drawn directly from their input. In the Dominican Republic, PRIME documented that increased consumer input is associated with increased client load (up 88% in one year) and improved perceptions of provider care (22% increase in overall client satisfaction and 84% increase in satisfaction with clinic services offered), making these consumer-provider collaborations win-win situations. In Rwanda, community members and providers found

that they agree on the majority of expectations related to quality services (from accessibility and technical competency to cultural compatibility and the availability of equipment, supplies and drugs); they have formed teams to work together, implementing solutions to resolve selected service issues. In India, consumers actually became their own "providers" in the Community Partnerships for Safe Motherhood project. Pregnant women and their caregivers were taught how to prepare for the birth and obstetric emergencies.

Give visible credit to change agents in the community

PRIME projects have found site-appropriate ways to recognize the leaders in efforts to change, from wall graphics to ID badges for community members who promote clinic services and gather feedback in their communities. To recognize the hard work of both providers and community members, PRIME projects have awarded certificates at special events to acknowledge these efforts and contributions.

Get implementers behind the effort

PRIME holds ongoing meetings with NGO leaders who are implementing changes, ensuring their buy-in. When program interventions are designed and implemented to gain community acceptance for family planning and reproductive health services, both provider and client benefit tremendously. In the Dominican Republic, PRIME was able to negotiate a dialogue between the NGO leadership and clinic staff on the need for the NGO to support community outreach. This involved minimal per diem, photocopy costs and a more flexible work schedule.

What are the key lessons in this area?

Early involvement of clients is essential

Strategies that inform and empower clients and their communities reach a critical point early in the process. PRIME has found it important to invest heavily during the first weeks of a project, allowing staff to respond quickly to issues as they arise and maintain high motivation levels of both providers and community members. With this early support, sustainable mechanisms for collaboration are bid out.

Flexibility counts

Providers and project staff must be extra adaptable when working with clients and potential clients, taking into account their time pressures from jobs and families. A significant amount of project time takes place in the evenings and over weekends, and in venues outside the clinic—schools, churches, stores and community centers.

Leadership support is vital

Service delivery leadership must facilitate and support the providers working in the community, making this aspect part of their clear job expectations. Both leaders and providers must be willing to go the extra mile, showing consumers that they have been heard. For example, when consumers in the Dominican Republic placed their priority on adding related services, the clinic was able to afford the part-time addition of two gynecologists, a cardiologist and two psychologists. When consumers in the Dominican

Republic emphasized the need for additional privacy, providers built taller walls and added a sound-proof ceiling.

Providers CAN learn the new client-oriented skills they need

Providers can be effective mobilizers of consumer input, but they must adopt new skills, become open to listening to their clients and potential clients, and learn how to change their practice in response to this input.

Question 2. Describe the challenges faced engaging clients and what strategies PRIME implemented to address these challenges and lessons learned.

While PRIME II is a provider-focused project, it is also mandated to inform and empower clients and communities.

PRIME's objective is to bridge the gap between providers and consumers, ensuring that individuals' preferences and needs are met by providers. PRIME has faced four particular challenges in efforts to engage clients:

- Providers must often change their attitudes in order to be open to consumers
- Health care consumers are tired from long hours of work and stretched to make ends meet for their families
- Organizational leadership is essential
- Provider-consumer partnerships, once established, must be ongoing and sustainable.

Consumers are busy and relatively unmotivated to spend free time in efforts to improve services

Recognizing that our work involves consumers who do not often have the luxury of free time, one of PRIME's most effective strategies has been to hold meetings between providers and consumers in locations convenient to the consumers: churches, schools, community centers, stores or homes. This helps the process gain momentum and encourages consumers to freely express their expectations (e.g., types of services, hours, prices, treatment and quality), describe barriers they face in accessing services, and share recommend changes. In the Dominican Republic, community participation at meetings was initially very low when PRIME launched its project under the Consumer-Driven Quality (CDQ) technical leadership area. As barriers to attendance became clear, however, the times and places of the meetings were readjusted and community participation increased and stabilized.

Providers must develop an open attitude toward hearing and incorporating consumers' ideas

As providers listen to consumer perceptions of services and quality of care, their understanding of client needs becomes more acute. After they make feasible changes in response, it has proven extremely important for providers to then go back to the consumers, or bring consumers to their facility, to demonstrate the consumer-motivated changes in action. All three steps are necessary for successful provider-consumer partnerships, as learned in PRIME's CDQ projects. In many cases, providers must not only be willing to listen to consumers but also change attitudes toward consumers. During a performance needs assessment in Nicaragua, for example, PRIME found that many pharmacists and drug sellers had clear prejudices against offering reproductive health services to adolescents. After awareness building workshops, these attitudes began to fade and the pharmacists also began to see a new market for their services. Providers in Uganda also developed a more open attitude toward their adolescent clients and listened to their

demands. Following focus group discussions with adolescents and parents, clinics expanded hours to accommodate youth and witnessed significant increases in the numbers of young people coming in for outpatient services, including laboratory and STI management. In Zambia, the nurses' association had not considered including consumer input in the development of national norms but became interested and open after several awareness building sessions with PRIME staff.

The leadership of the clinic and system must support the consumer orientation

Ongoing, vocal support for gathering and acting on consumer input must come from the leadership of the health care facility and larger system, modeling the importance of engaging clients. Ministries of health, professional organizations and USAID missions all play critical roles in emphasizing the relationship among client satisfaction, client input and the sustainability of a clinic or other facility. District health offices and facility managers in Rwanda quickly noted increased participation in prepaid health plans and use of services when community preferences were addressed.

Once established, the relationship between providers and consumers must be ongoing and sustainable

PRIME designed an ongoing bridge between providers and consumers into its projects as an explicit expectation. However, this bridge works only when it's easy, quick, inexpensive and beneficial to both consumers and providers. In the Dominican Republic, community leaders and clinic promoters gained status in the eyes of their community by working together to meet community health needs. Identifying this non-financial gain for key leaders means that activities are more likely to carry on without technical assistance. Similarly, tools developed by PRIME II as part of the CDQ toolkit, such as home visit interviews for consumers and community talk guides, continue to be used by providers. Due to these efforts, NGO leaders have witnessed an increase from 956 clients in the clinic's first quarter to 1925 in the final quarter of 2002 (one year later). The clinic has also benefited from an increase in the amount of money received from paying clients: from $750 in November of 2001 (before the CDQ project began) to $3,770 by February of 2003. These figures provide strong motivation for the NGO leadership to continue working in the community.

Question 3. What steps has PRIME II taken to ensure FP/RH clients make informed decisions about their fertility?

Because informed choice is fundamental to PRIME's mission, programs must be structured from the outset to allow each client to customize an individual family planning and reproductive health plan. Based on presenting all practical options, PRIME's approach encourages informed decision-making, positive client-provider interaction, and the reduction of medical barriers. We believe that improving provider performance includes ensuring that clients make informed decisions on family planning options and reproductive health choices. Placing this information in consumers' hands, in turn, promotes positive reproductive health behavior.

RH policies, norms, protocols and standards

PRIME II has collaborated with ministries of health and other partners in numerous countries, offering technical assistance to ensure that full informed choice is highlighted in policies, norms, protocols and standards for provider practice. In Paraguay, for example, the USAID mission asked PRIME to evaluate the effectiveness of the national reproductive health policy for 1997-2002. While the policy was relatively well written and included clear provider expectations for ensuring clients' informed choice, the evaluation found that it was hardly used or even known of by providers. PRIME is now facilitating the development of the next five-year national RH policy (2003-2008), ensuring that the agencies and associations who will use the policy participate in a more facilitative and inclusive development process. As a result, these organizations will "own" the policy, disseminate it and encourage providers to use it in everyday practice as they emphasize choice in regard to contraceptive methods and spacing or limiting births.

Pre-Service Training

Pre-service training provides excellent opportunities and a sustainable mechanism for teaching the concepts, working with the tools, and using the assessments that build in the concept of informed choice right from the beginning. In Mali, PRIME discovered that pre-service training benefited from involving teachers in the redesign of curricula, design of national training standards and dissemination of the standards. This participatory approach ensured greater buy-in for the curricula and standards, which include the overarching philosophy of informed consent. In Rwanda, we learned that the overall pre-service effort was more difficult when pre-service reported to the Ministry of Education while in-service reported to the Ministry of Health. This reporting mechanism made it especially challenging to integrate issues such as informed consent, since there was not a coordinated effort between the ministries.

In-Service Training

PRIME has taken advantage of its unique position with primary providers in over two dozen countries around the world to offer technical assistance on informed decision-making in reproductive health and family planning. Curricula and other training-related materials

developed by PRIME for doctors, nurses, TBAs, promoters, pharmacists and other providers all include the fundamental foundation for ensuring full and informed client decision-making on FP/RH issues. PRIME also uses tools for provider performance evaluation that include items related to ensuring clients exercise informed choice. In El Salvador, where PRIME has been involved in strengthening the national RH program at the primary level, informed consent is one of the key messages along with user perspective and interpersonal communication skills.

Informed choice and informed decision-making require that providers have accurate and up-to-date knowledge and information. For example, it is essential that providers of postabortion care are able to inform postabortion women about how quickly fertility can return. PRIME's postabortion family planning initiative in Kyrgyzstan, Uganda and Haiti is assessing this knowledge among PAC providers and clients.

Support Materials

The PRIME Project creates job aids for providers and, where feasible, includes client education materials such as posters, brochures and leaflets (mostly developed by other cooperating agencies) to emphasize the important message of fully informed choice. PRIME adapts existing materials whenever possible; for example, provider and client educational RH materials from the Dominican Republic were revised for use in El Salvador with input from local artists and focus group discussions with providers and clients. In this case, PRIME also negotiated that production and printing would be carried out by the MOH, ensuring local commitment to budget for these materials and produce them over the long-term.

Question 1. What approaches has PRIME tested and used for cost containment? What were the results of these approaches?

The PRIME II Project has successfully applied a wide range of programmatic approaches to contain costs. Most final results have yet to be collected and analyzed. However, feedback from USAID missions and ministries of health has been very positive in this area.

The missions and ministries indicate that even if the costs of PRIME's alternative programmatic approaches are not less, they still preferred these programs over other, more traditional approaches because they are more sustainable and demonstrate better provider performance. This added value is an important consideration when examining cost-effectiveness and unit costs of performance improvement options. Examples of cost containment for programmatic interventions include:

Cost and Results Analysis (CRA)

PRIME has developed and applied workable methods for analyzing the costs and results of programmatic alternatives that respond to the realities of low resource settings (e.g., alternative learning approaches, alternative supervision, learner support approaches). These methods link the costs of activities with their results. PRIME has applied CRA methods in Honduras and Ghana; a number of other applications are in process.

In Honduras, facility accreditation is an important step in health sector reform. PRIME is assisting the MOH to compare the overall effectiveness and the cost-effectiveness of alternative approaches for reinforcing reproductive health performance standards in accredited facilities. The approaches being tested represent alternative ways of providing supervisory support to providers: traditional external supervision, self-monitoring and peer support.

In Ghana, PRIME is working with the MOH and the MOH Health Research Unit to compare the overall effectiveness and the cost-effectiveness of alternative learning approaches for providers of Safe Motherhood services. A self-paced learning (SPL) approach that involves learners working in pairs is compared with a more classroom-based approach. In both of these activities, costs measured include more than the direct training costs—the costs of the provider's time is a significant factor, including travel and waiting time for activities such as peer support and meetings with tutors or clinical practice facilitators. Opportunity costs such as missed client visits are also considered.

CRA Supports the PI Process

Project staff presented PRIME's experience with the CRA strategy, tools and results at the Training Best Practices conference held in Washington (Spring 2002) and at the Africa Training Best Practices conference in Lusaka (August 2003). As a component of the PI approach, CRA contributes to the identification, selection and subsequent evaluation of interventions that close performance gaps. PRIME has adapted methods of costing health service delivery to the non-clinical context, costing activities such as training, supervision, and peer support. Cost data are then linked with results data from routine monitoring and evaluation or from special studies in the form of cost-effectiveness analyses.

South-South Collaboration Reduces Costs

The costs of developing new materials such as guidelines, curricula and job aids can be high. They include labor and participants' time away from their jobs. Many hidden costs surface due to duplication of effort and technical reviews. When materials can be developed in-country, the benefits are numerous. For example, national stakeholders gain a greater sense of ownership of the materials. To minimize developmental costs, PRIME has encouraged frequent dialogue on technical approaches, documents and problem-solving across activities and projects. Examples of the South-South exchanges the Project has fostered include:

- PRIME has adapted a preventing postpartum hemorrhage (PPH) curriculum developed in Mali for use in Benin and Ethiopia
- National reproductive health standards that PRIME developed in Mali relied on similar documents from Morocco
- Supervision curricula and job aids developed for Honduras and Ghana have informed similar activities in Senegal and Kenya
- Safe Motherhood curricula and materials for Ghana, Guinea and Yemen have been adapted for use in Armenia, Nicaragua, Paraguay, India and Bangladesh
- Materials developed to train health promoters in Nicaragua have been used in El Salvador and Paraguay
- The PRIME Project's leadership roles in the MAQ Exchange, the PI Consultative Group, the PAC Consortium and Francophone PAC have provided further opportunities for this exchange of technical approaches and with other CAs.

PRIME has also reached out to other donors and encouraged them to share the costs of development and printing of materials. For example, in Ghana, both UNFPA and the World Bank participated financially in the development and dissemination of national RH protocols. Their support allowed these materials to be more widely available throughout the country. In Honduras, PRIME has had extensive cost-share with JICA, PAHO and others.

Question 2. How well has PRIME designed their global and country-level activities to complement the activities of other CAs, NGOs and stakeholders?

Ensuring that PRIME activities are aligned with USAID efforts, the Performance Improvement approach is an essential framework for the Project's initiatives to improve FP/RH service quality, accessibility and use. This complementary niche has proven extremely useful at the global and country levels and has kept PRIME's technical assistance in high demand. The PI approach becomes a value- added to almost any effort to improve reproductive health care.

To leverage and maximize resources, PRIME has consistently and successfully designed global and country-level activities that complement activities of other CAs, NGOs and local stakeholders. The Project's commitment to partnering has been an important factor in PRIME's ability to generate increased levels of core and field support. At the country level (e.g., Mali, Benin, Uzbekistan, El Salvador), bilateral project staff from other organizations and key stakeholders such as the MOH have often requested that USAID missions fund PRIME technical assistance. PRIME's commitment to working with global partners is reflected in one of the Project's ten key PMP indicators. In the latest (August 2003) PMP report, PRIME shows work with more than 30 institutions in partnership agreements.

PRIME has provided global leadership in Performance Improvement by serving as co-chair of the Performance Improvement Consultative Group, as well as facilitating PI courses. PRIME has served as co-chair of the MAQ Community-Driven Quality subcommittee. Through a joint effort with the Postabortion Care Consortium, PRIME also developed a quality of care framework for the expanded and updated PAC model with Ipas, Pacific Institute for Women's Health and other key global partners. At the regional level, PRIME has collaborated with multiple CAs to organize and host technical initiatives ranging from the 2002 Francophone PAC Conference in Senegal to a MAQ Exchange in Mali with key CAs and stakeholders. In Year 5, PRIME will work with partners to create a regional MAQ strategy for Latin America and the Caribbean linking the MAQ model with the LAC ob-gyn federation, FLASOG.

At the country level, PRIME's ability to generate field support funding is testimony to our success in designing complementary activities with other CAs, NGOs and stakeholders. Highlights include:

Ethiopia

PRIME has led the partnership effort for the Prevention of Mother-to-Child Transmission of HIV (PMTCT) initiative, which includes PRIME II supporting institutions Save the Children and ACNM along with the CDC, UNICEF, JHPIEGO, and USAID Global Projects, Linkages and MSH/RPM+. PRIME is collaborating with the MOH, the CDC and JHPIEGO to implement a PMTCT intervention and create three centers of excellence at hospitals in Addis Ababa. ACNM proposes to complement these activities by strengthening the performance of providers in PMTCT at health centers and health posts, and by working with Save the Children to develop community strategies that will increase awareness of HIV/AIDS and encourage use of improved facilities.

Rwanda

PRIME has collaborated with FHI/IMPACT Project to expand PMTCT services at three sites to include voluntary HIV counseling and testing, followed by single-dose nevirapine for the mother at the outset of the labor, and for the newborn. IMPACT's VCT training materials were used for provider training and IMPACT and PRIME have jointly carried out the training of laboratory technicians at each site.

Armenia

PRIME II has signed (or will soon sign) collaborative memorandums of understanding with three international agencies (Carelift, Abt Associates, International Relief and Development) and with local NGOs including the Women's Rights Center. Carelift International has provided donated medical supplies for project health posts, as well as for the Center for Perinatal Obstetrics and Gynecology. International Relief and Development supplies essential drugs to health posts. And Abt Associates collaborates with PRIME in the implementation of the Integrate Reproductive Health in Family Medicine and Primary Health Care Initiative.

Nicaragua

PRIME II has worked in a coalition with NicaSalud partners Project Hope, ProjectConcern International, Wisconsin/Partners of the Americas and Catholic Relief Services, in addition to the MOH. A recent qualitative evaluation assessed the integration of the various partners in the consortium. One of the strengths expressed was the ability to "demonstrate to ourselves and the MOH that united we are more credible and can develop and implement a strategy of various components at the institutional level as well as in the community." All partners shared resources and capitalized on their various organizational strengths. A downside to this partnership is an often-cited time lag in project implementation due to the difficulty in obtaining approval for project design from so many different entities.

Question 3. Describe how PRIME implemented the four TLAs to achieve the IRs. How were lessons learned and best practices utilized in the implementation process?

The technical leadership areas were not specified as part of PRIME II's original design or cooperative agreement but were added in the first year of the Project to help focus our efforts in improving primary provider performance. Both process and technical content areas were chosen: Performance Improvement (PI), Responsive Training and Learning (RTL), Consumer-Driven Quality (CDQ) and Postabortion Care (PAC).

For Year 5, HIV/AIDS Integration with Family Planning has been added as a TLA. Indicators were developed for each TLA project application. TLAs are also reflected under—and contribute to—the ten key indicators of PRIME's Performance Monitoring Plan (PMP) that are linked with the Intermediate Results. For example, the PI TLA supports the overall Strategic Objective (key PMP indicator #1), IR2 (key PMP indicators #5 and #6) and IR3 (key PMP indicator #7), while the RTL TLA is represented primarily by IR1 (key PMP indicators #2, #3 and #4). CDQ (now Integrating Consumer Perspectives) is represented primarily by IR4 (key PMP indicators #8 and #9). The PAC TLA is technical in nature and as such renders itself well to represent all four IRs.

For each TLA, two co-chairs lead a global (or virtual) team. The teams range in size from 10 to 20 members, including representation from US-based and field offices. One co-chair is from IntraHealth and the other from a partner organization, which has successfully maximized the strengths of the PRIME partnership. Although the approach has varied across the teams, most teams meet face-to-face once a year and hold telephone meetings once a month or every other month. The teams review the major issues and challenges in their TLA as well as state-of-the-art thinking in related subject areas. At times new approaches recently tested and proven in western countries have been considered and adapted for low-resource settings. Teams follow a general long-term (usually five-year) strategy and brainstorm on ways to solve problems and move forward in the TLA area, designing innovative projects primarily using core funding. TLA project progress is judged in light of contributions not only to the technical area but to PRIME's IRs and PMP indicators. Teams also seek to inform and update other PRIME staff about their TLA and integrate their ideas into field support funded projects to the extent possible. USAID/Washington staff frequently participates in significant meetings such as "Think Tank Days" and in strategy review.

As monitoring data and results come in from projects designed or influenced by the TLA teams, they are shared within and outside of PRIME and used to modify ongoing projects and design new initiatives. For example, PRIME's experience has demonstrated the importance of addressing the profit motives of private-sector providers; training and non-training interventions that address these issues are now being tested and are showing the need for further experimentation and documentation of the impact of non-training interventions.

At a recent meeting of the Partner Leadership Group, PRIME reviewed keys to TLA successes including keeping the global teams to a reasonable size (less than 15 members), ensuring strong communications and periodic face-to-face meetings, offering training or updates to all TLA group members and orienting field staff about the TLA. Adequate core funding and time are necessary to design and implement innovative projects. In sum, PRIME has found the TLA approach instrumental in the translation of contractual language (e.g., IRs) into technical initiatives and very useful for fostering team work, gathering the best thinking from many experts, generating new ideas, designing pilots and producing results in a focused area.

Question 5. Describe the structure of IntraHealth before July 1, 2003 and its impact on the PRIME project's mission.

Prior to July 1, 2003, the Intrah Program in the School of Medicine at the University of North Carolina-Chapel Hill (UNC), served as a cooperating agency with USAID's Office of Population. For more than 20 years, the Intrah Program implemented a series of large global projects supported by the Office of Population; the PRIME II Project is the latest in that series.

The Intrah Program was housed in the Office of the Dean of the UNC School of Medicine, subject to the rules and operating systems of UNC. Intrah was led by a director who reported to the Dean. Because of its public-sector status, the university is subject to many of the rules of the government of the State of North Carolina. Intrah, for example, was required to use the indirect rates assigned by UNC and to follow UNC procurement rules. Recruitment for positions at Intrah normally followed UNC personnel processes, most of which are based on state government procedures and are extremely rigid in terms of steps required to establish a new position or hire (e.g., preference given to other UNC layoff candidates; restrictions on advertising). Intrah adopted UNC accounting practices and utilized the university's office of contracts and grants for sub-contracting.

Over the years, this relationship worked fairly well until the size and complexity of the global awards increased. University requirements began to hamper our ability to respond to USAID in a timely manner; our cost competitiveness began to be affected. During PRIME I and PRIME II, representatives from USAID increasingly raised questions about the speed and ease of certain management systems (such as recruitment and procurement) as well as their costs. Implementation agility was an issue at times, because the rules and regulations of a state university were not well suited to the needs of a global project. The university's regulations assumed that work was taking place in North Carolina—not Bamako or Dhaka. Understanding the limitations of procurement, UNC and Intrah introduced the concept of an independent (private) procurement agency (AMEG) to support the PRIME II cooperative agreement in project year one. Other systems remained relatively costly and slow. However, these systems issues did not inhibit the technical quality or innovative nature of PRIME's work. In fact, the affiliation with UNC enhanced the technical quality of the work, promoting interaction with UNC schools and access to relevant research results.

In the spring of 2002, representatives from USAID encouraged UNC to consider alternative structures for implementing projects such as PRIME II. After several options were explored, Intrah leadership, UNC and USAID representatives made a joint decision to form a non-profit corporation legally separate but still affiliated with UNC. This new status officially began July 1, 2003. It allows the new non-profit organization, IntraHealth International, Inc., to operate as a flexible, private-sector corporation with improved implementation efficiencies—including quicker response time for operationalizing the PRIME II mandate. Already, in 2003, approximately $1 million is expected as savings in overhead costs made available for direct programming.

Question 6. How does IntraHealth involve other partners in the PRIME project? Are partners sufficiently involved in major project decisions? Please give examples.

IntraHealth and the PRIME II partner organizations recognize the value that our active, cooperative partnership structure contributes to achieving our major objective, improving primary provider performance in countries around the world. This structure requires all involved to invest time and resources in building and maintaining an outstanding partnership.

IntraHealth and the other partners have worked hard to ensure that all organizations are actively involved in PRIME II. There are several significant mechanisms the partnership uses to achieve a high level of involvement. In addition, the Memorandum of Understanding lays out clear guidance for the partnership.

Partner Leadership Group

The Partner Leadership Group (PLG) is PRIME's first mechanism for involving partners, helping to share information and decision-making issues (also described in Management Question 11). This group of two senior-level staff members from each partner organization meets three times a year. The PLG provides leadership across the entire project to ensure that strategic planning, resource allocation and performance monitoring lead to the desired outcomes in the cooperative agreement. The PLG confers on a wide range of topics, such as building strategies and reviewing the progress of all Project-wide key technical leadership areas (TLAs). The PLG considers "big picture" technical progress throughout the Project, reviews financial reports and monitors how resources are being used, and works to resolve problems that arise throughout the life of the Project.

The partnership created and endorsed a Memorandum of Understanding early in the life of the Project to guide the PLG and remind stakeholders of the principles of the partnership. The Memorandum includes protocols for communicating with USAID missions, subcontracting precepts and other important business of the partnership.

TLA Co-Chairs

Each PRIME II Technical Leadership Area is led by two co-chairs, one IntraHealth or Chapel Hill-based staff member and one partner staff member. The co-chairs manage, lead and are held accountable for the work activities being performed in that technical leadership area. In addition to partner co-chairs, a number of seconded staff from partner organizations fills key full-time positions at headquarters in Chapel Hill.

IntraHealth has worked to ensure that the partnership operates in and beyond headquarters, so that it is equally alive and active in the field. Appropriate partner organizations participate and have a voice in decisions at the country level and at regional levels of the Project. In the beginning of the Project, start-up activities were held at headquarters and in each of the regions to ensure that good partner relations were established on many levels. (Additional information on the partnership can be found in responses to Management Questions 11 and 13.)

Recent examples of partners' involvement in Project efforts include:

- the consultation and joint work to develop this year's annual workplan
- the decision to create a new TLA: HIV/AIDS Integration with Family Planning
- participation in determining key learning from the Project (the July 2003 Results and Communications Workshop).

At various times over the life of PRIME II, partner organizations have assessed the partnership, allowing us to check that all partners are appropriately involved. Partner organizations have expressed a high level of satisfaction with the operation of the partnership.

Question 7. Explain why PRIME field support has increased every year.

The PRIME II Project has fulfilled the promise built into its design, improving reproductive health care by improving the performance of primary providers around the world. The designers envisioned that this work would be recognized by USAID missions and attract field support as our technical approaches produced substantial results. Here, too, the Project has met with considerable success.

The PRIME Scope of Work is Relevant to the Field

PRIME has been responsive to service delivery trends such as decentralization and health sector reform, and missions have been quick to realize that their country strategies and needs for technical assistance dovetail with PRIME's mandate. Since PRIME focuses on primary-level providers, the Project work at the nexus where communities and the health care system meet. For practical implementation and the ability to make a real difference in the lives of women and their families, missions turn to the PRIME teams in their region. They recognize that the PRIME paradigm includes all factors that are required for a provider to be successful in delivering services. The solutions PRIME develops with this provider-centered focus help missions prioritize interventions and identify new assistance that complements the full mission portfolio of projects.

PRIME Technical Teams are Responsive and Flexible

Technical teams from PRIME regional offices, headquarters and partner organizations all take USAID mission requests very seriously, making every effort to provide on-target technical assistance. We listen well and work to meet the needs on the ground as articulated by the missions.

PRIME Technical Assistance is High-Quality, Professional and Proven in the Field

Missions have appreciated PRIME teams' up-to-date technical knowledge, as well as the sensitivity to cultural contexts that allows the Project to work effectively in many societies and with all levels of counterparts.

PRIME Emphasizes Measurement of Results

PRIME technical teams are serious about establishing baselines, monitoring progress, measuring changes post-intervention and documenting these changes. With this hard data, missions report their work more effectively and improve their collaboration with colleagues at USAID/W. PRIME can show results, even at the most difficult-to-measure primary levels of care. With this information, the Project helps generate support for the larger USAID mandate and global public health goals. Our decentralized management system with strong regional offices as the locus for strategy development has proved very beneficial. Access to PRIME II's expertise is facilitated through quick and easy contact with missions.

Question 8. What have been the greatest challenges the PRIME project has faced in implementing the PRIME II Cooperative Agreement? What strategies were implemented to deal with the challenges? What were the outcomes?

Considering the scale and scope of the PRIME II Project, remarkably few obstacles to implementation have been encountered. Here are some of the more significant challenges and the steps PRIME took to overcome them:

Balancing Field Priorities with USAID/W Priorities

At times, the needs of the field did not match the priorities of the Office of Population. For example, during PRIME I and early in PRIME II various country missions asked PRIME to support their HIV, maternal health and child health endeavors. Missions were interested in this role for PRIME because of our strength in building the capacity of primary health providers. In many instances, however, these technical areas outside of family planning were not priorities for the Office of Population. PRIME staff negotiated our response to such mission requests with USAID/W on a case-by-case basis, and at times USAID/W and the missions discussed the situation directly and worked out a solution.

The recent Global Bureau for Health focus on integration has eased some of these decisions, provided we can show how FP is linked to other services (or vice versa). PRIME is anxious to share its lessons on PI with other technical fields, such as HIV/AIDS—all in service of improving primary providers. Because of our history, much of PRIME's work has focused on family planning, but the Project has gathered some intriguing evidence that the PI approach can be successfully applied to other areas like HIV, PAC, safe motherhood and preventing postpartum hemorrhage; we also have developed experience in the area of FP and HIV integration.

PRIME saw the effects of different priorities when missions sometimes were not interested in the innovate approaches that PRIME was pioneering. Instead, they requested very traditional approaches like training alone, without a performance needs assessment to support that intervention choice. PRIME worked hard to introduce and "market" its technical leadership areas and dovetail the PI approach with mission programs and agendas, but this was a challenge in some cases.

Communicating and Staying Focused in a Large, Complex and Decentralized Project

PRIME II manages activities in more than 25 countries, ranging from $100,000 interventions to large country programs of $2.5 million per year. With a fairly decentralized implementation structure, it is a challenge to ensure that all of the sub-projects are cohesive, follow global standards, and contribute to the established results and performance indicators.

PRIME leadership employed a variety of strategies to meet this challenge, including:

- Setting up and implementing global (virtual) technical teams to allow for cross-regional communication and skill building

- Along with face-to-face meetings in Chapel Hill and the field, establishing rapid communication channels including e-mail, the Intrahnet, instant messaging, and, of course, telephone conference calls
- Developing and practicing a communications strategy that involves a variety of communications products and formats that are now widely recognized (e.g., PRIME Voices, PRIME Pages, Dispatches, presentations and an extensive, well organized website) to share lessons learned both within the Project and with external audiences
- Recognizing the value of using our performance monitoring plan to keep sub-projects focused on key indicators and required results.

These mechanisms have helped the project to focus on making a difference in the health of women and their families around the world, achieving the results required by the cooperative agreement.

Pressure for Quick Implementation and Results Versus the Need for Analysis of the Problems, Planning and Monitoring

While USAID (in Washington and country missions) and other CAs, like the PRIME II Project, are all staffed by seasoned professionals dedicated to the "long haul," there is always a temptation to look for the "quick fix." However, sometimes this wish for quick change means that PRIME receives requests from USAID missions for training efforts that are not based on a thorough needs assessment.

Experience and evidence show that training alone is rarely the solution to a performance problem, and sometimes training is not the intervention needed. PRIME has tried to address this paradigm shift by explaining the need for an analysis (performance needs assessment) of the problem as the way to determine the appropriate solution. It has also been a challenge to convince missions and, at times, USAID/W of the need to fund careful monitoring and evaluation to ensure that new approaches are working as anticipated. Related to this issue, PRIME has found that it can be a challenge to change attitudes when under pressure to conduct traditional training rather than to consider more innovative and blended approaches.

Because the timeframes of USAID missions are often different from those of PRIME, it can be difficult to finish plans or collect results from field support projects on the PRIME schedule. PRIME has generally been able to balance these needs, largely because of the Project's decentralized structure with Regional Offices and Country Offices. This has helped to ensure that PRIME understands the mission's needs and timing as well as USAID/W priorities (See response to Management Question 10). The Project's Performance Monitoring Plan (PMP) has helped reconcile these different approaches, as staff uses the PMP to show missions the indicators the Project is responsible for fulfilling, which include conducting PNAs and implementing strong monitoring and evaluation plans. Thus, in most cases PRIME has successfully introduced the PI approach; however, in some instances the Project has not been able to implement PI fully and has not been able to document results optimally.

The USAID Funding Cycle

In the current system, projects like PRIME are notified of the resources available at the end of the fiscal year, well after USAID has already requested new workplans and budgets. This

funding cycle is a challenge for all CAs. It requires significant work and negotiation with partners at the global and national levels, which then needs to be re-done after the funding level is approved. The Office of Population has assisted with this dilemma by requesting the completed workplan later in the fiscal year (closer to the time funding levels are known). PRIME has been able to manage by re-doing its budgets after the funding level is approved; however, when the approved level is significantly lower than the expected levels, as it was in 2003 for PRIME, this caused significant extra work and disappointed many partners and stakeholders—including USAID/W and mission staff who have led in developing certain initiatives. Multi-year allocations would greatly help with this problem.

Question 9. Regarding USAID management; describe your relationship with the CMT, FPSD, and SDI Divisions throughout the life of this agreement. What have been the strengths and challenges? Describe your relationship with the CTOs and TAs throughout the life of PRIME. What have been the strengths and challenges?

The PRIME Project has enjoyed a constructive relationship with the USAID CMT, FPSD and SDI Divisions and the staff members of each group with whom we've worked. Although there have been some constraints in the USAID system, such as periodic changes in structure and staff, overall the PRIME Project has benefited from valuable guidance and input from the Division staff.

Strengths of the management relationship include:

- Support from USAID to explore new areas, such as the importance of consumer feedback and the integration of FP with HIV
- Support and understanding from our CTOs in dealing constructively with the tensions that sometimes arise as we work to be responsive to agendas of USAID/W and USAID country missions
- Establishment of strong, regular communication channels, such as weekly teleconferences, monthly CA meetings in Washington, and periodic visits by USAID CTO and STAs to the Chapel Hill offices
- A well-managed transition from the CMT structure to the SDI structure, with good information sharing on the reorganization process.

The challenges include changes in the USAID staff assigned to manage the Project (Cognizant Technical Officers and Senior Technical Advisors) and the (sometimes related) changes in priorities and messages from USAID/W. Because the Project has worked with two CTOs and three STAs over the last four years, some shifts in messages were inevitable. When the STA has little experience in international reproductive health or with USAID procedures, however, it becomes particularly burdensome on the Project to orient this staff person and difficult for the Project to get vital information and assistance from the Agency. In addition, it is problematic to assign two large projects (which compete at times) to the same CTO or STA.

Priorities shifted in RH content areas, as well. When PRIME first proposed working on integrating HIV and FP services in mid 2000, this strategy was accepted in principle, but not funded. Later we were not really encouraged to pursue HIV opportunities, but to focus on family planning; then in early 2003 HIV integration was again encouraged. At that point, in fact, we were told that we were behind the times in addressing HIV and integration issues. Even though they are frustrating, changes like these are to be expected in such a dynamic field. Overall, the working relationships with staff in the various divisions have been very positive and productive.

Question 10. PRIME is a decentralized management system with four regional offices. Describe the benefits, challenges and costs of the system; provide a cost/benefit analysis.

PRIME's decentralized management system has enabled the Project to build and maintain effective relationships with USAID missions, as well as with our public and private sector counterparts. The chief benefit this system offers missions and counterparts is easy access to PRIME expertise, facilitated by our shorter response times in answering requests and our ability to provide timely assistance.

PRIME's strategic position in supporting bilateral efforts is a particularly attractive feature of our decentralized management system. The relationships PRIME enjoys with missions and counterparts, together with PRIME's capacity to manage field activities closely and deliver consistently high technical performance, have contributed directly to levels of field support funding that are among the highest in the Office of Population's global projects. Two of the PRIME II partners, EngenderHealth and PATH, have analyzed the PRIME II experience with decentralized management and decided to start or return to a regional office structure. Benefits of PRIME II's decentralized management system include:

Local Presence

The four PRIME II regional offices (Dakar, Nairobi, Bangkok, Santo Domingo) afford a continuous local presence for PRIME II and are staffed predominantly by local staff. PRIME II's country offices are also staffed largely by local personnel. Each Regional Director is known within the region as an ourstanding RH leader and manager.

By locating within the region, PRIME is able to stay abreast of RH trends, understand the local context, be culturally effective, and have staff with local language capabilities. The local technical talent hired by PRIME is also well known in the region for high standards and quality technical assistance.

Responsiveness to Requests

Regional decentralization enhances PRIME's ability to respond to local USAID missions and counterparts. The regional offices work on significant projects in the countries where they are located or in countries relatively close by. As a result of our in-region locations, we are frequently able to respond within hours or, at most, a few days.

Technical Input

With a strong regional presence, the Project is able to provide greater and more up-to-date technical input and oversight. Our outstanding partnering skills result in higher quality products and sustained relationships with our clients. In turn, this provides the Project with opportunities for multi-year funding and programming. The mutual trust and respect that develop between the stable regional office, country staff and counterparts could not be achieved as smoothly with intermittent visits from outside the region.

Financial Accountability

PRIME II responds effectively to its fiscal obligations, empowering each regional office to receive and process monthly financial reports from country programs in the region before sending them to Chapel Hill. This helps ensure the quality of our financial reporting and increases the regional managers' ability to work within their established budgets. Each regional office financial director understands local constraints and realities in depth, while also respecting and upholding USAID financial requirements. The back-and-forth between the regional office and the country program financial staff occurs in the local languages, and issues are resolved more effectively.

Leveraged Region-Specific Funding

With regional management, PRIME has been able to better leverage USAID funds, increasing the financial and technical involvement of other international donor agencies, including UNFPA in Benin and WHO and UNFPA support in sponsoring the May 2002 Regional Francophone PAC conference in Senegal. PRIME's decentralized management structure has been a key element in our ability to leverage funding, as our regional staff is in an excellent position to interact with those institutions and with national decision-makers.

Among the challenges posed by the decentralized system are:

Synchronizing Regional and Headquarters TA

The primary challenge of our decentralized management results from a strength mentioned above. With the ability to relate in an effective and culturally sensitive manner, and under inevitable pressure from USAID missions and client institutions for a quick response, we realize that sometimes communication back to Chapel Hill headquarters is insufficient. In addition, the RO responsiveness that contributes to high levels of field support can be slowed down when routed through Chapel Hill. While Chapel Hill staff ultimately provides sound technical guidance and input to issues at hand, there are occasions when time is lost in technical reviews, revisions and finalizing products that require CH inputs. These communication challenges are not at all uncommon in projects that have headquarters and field offices.

Aligning Technical Leadership Area Activities with Field-Supported Work

By plan, the locus of design and management of technical leadership area (TLA) activities is in Chapel Hill. By the same token, field support projects tend to be created and implemented regionally and locally. Thus, a second challenge to our decentralized system is the ability to weave innovative TLA-driven elements into field supported efforts. Due to cost and timing considerations, occasional resistance from mission HPN officers, and the perennial low absorptive capacity of beneficiary institutions, field supported efforts do not always take full advantage of TLA concepts and lessons. There have been times when concerns were raised by a mission that core activities were "competing" with field supported programs. To address any inefficiencies or missed opportunities brought about by this tension, PRIME II worked to ensure that key staff from all the regional offices and selected country offices participates in global technical teams for the TLAs. These global teams meet face-to-face once a year, greatly enhanced by ongoing communication by e-mail lists,

individual exchanges and monthly conference calls. While the Project has made some inroads and encouraged South-to-South information sharing, some challenges remain on how to reduce the information gap between headquarters and field staff, and how to achieve greater synergies between core and field supported efforts.

Harmonizing Project Priorities

A third challenge, related to the second one, stems from a tendency of field staff to regard field supported activities as their priority, while headquarters staff place more emphasis on core activities, technical leadership and attention to innovation. While all of the work is for the same overall client, there are important differences in the agendas of both client and PRIME II representatives in different locations. Our efforts are to find the ways each complements the other, creating harmony and win-win situations.

Cost/Benefit Analysis

As outlined above, the benefits of maintaining a decentralized management system far outweigh the costs. The regional offices strive to participate directly in work in the region, maximizing the "billability" of costs to core and field support project accounts. Staffs of the regional offices provide technical assistance to projects on an as-needed basis. In response to recommendations made by the PRIME I final evaluation team, PRIME II brought management of program implementation closer to the field. The number of country offices, financed entirely by field support, grew significantly. In general, the Project has been successful in filling field positions in a regional or country office with nationals or third country nationals. While there are opportunity costs associated with efforts to identify, train and promote local cadres that can substitute for more costly technical assistance from the US, PRIME was able to transfer skills and build capacity while decreasing dependency on headquarters for more routine functions such as direct training assistance and training follow-up and monitoring.

PRIME II's Europe and Eurasia (EE) region is designed around a management system slightly different from the LAC, Africa and Asia regions. In EE we have no regional office and no regional director, but a country program and office in Armenia and smaller programs without local offices in two other countries. PRIME has experienced both benefits and costs by not having an EE regional office. Without a regional office and a team of regional experts in Armenia, PRIME programs rely more directly on Chapel Hill technical assistance and staff travel. Without the regional office as an intermediate step, programmatic and financial reporting is more streamlined with lower costs. However, since EE is a uniquely organized region, Chapel Hill technical and financial personnel tend to treat it like the other regions, as if it has a regional office. This can lead to higher-than-usual expectations of the sole country office.

Question 11. Describe the benefits and challenges of your consortium partnership, from both a programmatic and cost perspective. Provide a cost/benefit analysis.

Like many large USAID global projects, PRIME II is designed for implementation by a consortium of partners who bring a broad set of complementary skills and capacities rarely available from a single organization.

The PRIME II partnership has proven exemplary in:

- Integration of leaders from partner organizations into the Project's technical agenda and direction
- Collaborative decision-making on the management of the consortium.

Hallmarks of the successful and practical implementation of the PRIME II partnership include:

Partner Leadership Group

Composed of two senior representatives from each partner organization, the PLG provides a consistent mechanism for direct participation in the Project's strategic direction and technical leadership. This tight-knit team meets three times a year, rotating venues among partner offices.

PRIME II Partnership Memorandum of Understanding

At the outset of the Project, the partnership worked together to develop the PRIME II Partnership Memorandum of Understanding (MOU). This document provides transparent and practical guidance, with agreement and support from all partners, on topics such as Partnership Structure and Process, Annual Planning and Subcontracting Process, New Opportunities and Responding to Requests, Credit and Acknowledgement, Representation, and Prioritizing Technical Assistance Requests.

Seconded Staff

The PRIME II partnership operates daily, in a very straightforward way, through seconded staff from five consortium members (four partners and one supporting institution) based in the Chapel Hill headquarters. In addition, a number of partner staff are based in PRIME field offices.

Collaboration in the Field

The same cooperative relationship established among the US offices of partner organizations extends to partner regional and country offices. This collaboration frequently proves valuable in identifying new opportunities, helping start new country programs (in Honduras, Rwanda and Armenia) and sharing experiences and resources (in Kenya and Ghana).

Benefits of Partnership

A number of significant benefits arise from the PRIME II partnership:

- The Project benefits by gaining easy access to the partners' diversity, complementarities, technical expertise and management know-how.
- The sense of common purpose and shared commitment helps us define together the Project's technical leadership areas and cutting-edge technical agendas in a collaborative and technically synergistic manner.
- PRIME draws on all partner organizations to work in interdisciplinary global teams, developing strategies to move cutting-edge technical agendas forward. This has helped us scale up new initiatives faster and more powerfully. For example, the PI framework has been simplified, clarified and disseminated within the partnership, and then externally. This was accomplished at a faster-than-normal pace, with more buy-in and contributions from a wider range of organizations than otherwise possible. Also, the simplified framework has moved to the field level more quickly, and has been used successfully in more organizations than is typical.
- The Project secures funding for new and major country programs. Partnerships expand to new countries faster, bringing more depth of technical expertise and management know-how to country programs, and leveraging contributions of other CAs and donors.
- Because our PRIME II partnership is effective, it decreases USAID's management and technical load; the Project assumes more of the management burden and offers a greater range of technical competencies.

Challenges of Partnership

Naturally, there are challenges in building and maintaining a partnership like the PRIME Project. These include:

- Establishing and maintaining an effective partnership like PRIME takes leadership commitment and resources. This level of commitment within PRIME II is exceptional among projects. A trusting, synergistic partnership cannot be built and maintained without this commitment.
- No partnership or consortium model is perfect. In spite of the transparent and participatory annual subcontract amendment process, partners may still feel their technical resources could be utilized more fully.
- Because the PRIME II Project is large and complex, it is challenging to make sure that appropriate staff members from each partner organization stay fully informed about project developments. At the same time, the partner organizations have many different specialties and areas of expertise. It can be daunting for PRIME II staff to stay fully aware of the capabilities of partner organizations and ready to access these competencies as the work of the Project develops.
- When some of the partner organizations compete with one another for other project awards (such as country bilateral projects), keeping the partnership alive and functioning appropriately in the field requires commitment, trust and goodwill. Fortunately, PRIME has attracted staff with an immense regard for the important role of primary providers; our team members have been quite willing to make other considerations secondary to their work to improve primary reproductive health care for women and families in greatest need.

Cost/Benefit Analysis of the PRIME II Consortium Partnership

PRIME II estimates the annual cost of the partnership at about $210,000. This figure includes the costs of three PLG meetings per year, participation by partner representatives as co-chairs and participants in the TLAs, and management review assistance from partners, including participation in other ad-hoc meetings. When annualized and compared with the Project's budgeted funding of $58.9 million as of June 30, 2003, this investment in the partnership is about 1.25 % of the Project budget.

PRIME II has received a cumulative total of $28.9 million in field support funding from 16 countries as of June 30, 2003. Partners have made significant contributions to Project field support levels, helping PRIME II establish country programs and attracting increased field support for existing programs. Some of PRIME's larger country programs (Rwanda, Armenia, Ghana) have benefited from partner involvement beginning with program initiation and continuing all through technical implementation.

While PRIME II considers itself an effective partnership, we have estimated the costs of ineffective partnerships to offer an enlightening comparison. Time and money can be spent trying to solve "aggravated" problems and smooth over disagreements. Ineffective partnerships can also result in lost opportunities, including lost field support funding and limited synergy. In a hypothetical example of an acute case of ineffective partnership, an issue with a country program might require a "fix-it trip" by two persons (or two trips by one person), along with other labor and communications costs. Including indirect costs, resolving an acute situation could cost $80,000. Estimated annual costs of lost productivity due to a chronic case of ineffective partnership in a large global project are $500,000. (Please refer to PRIME II [McCaffery/Killian] PowerPoint presentation at USAID Office of Population dated October 9, 2001, for assumptions and details of calculations). Note that the estimates presented here are based on conservative assumptions regarding the negative impacts of ineffective partnerships.

Question 12. Describe the factors affecting the decision to establish the new TLA, HIV/AIDS and Family Planning Integration. What was the rationale for removing Consumer-Driven Quality (CDQ) as a TLA? Why was it moved to the Performance Improvement (PI) TLA? What were the lessons learned?

In the spring of 2003, the PRIME II Project discussed the possibility of adding a new technical leadership area, HIV/AIDS Integration with Family Planning. The key role that primary providers can play in preventing and managing the further spread of HIV has never been clearer. With support from the SDI Division and specific encouragement from the Senior Technical Advisor in Washington, PRIME leadership vetted the creation of the new TLA with project staff and the Partner Leadership Group.

PRIME had established a task force early on in the Project to explore opportunities for integration and an expanded role in HIV/AIDS but had limited funding to support activities within that strategy until Year 4. Despite the lack of funding for specific HIV interventions, PRIME has had success with integrating HIV/AIDS into FP/RH activities. The timing was ripe given our growing experience in HIV integration activities in Africa and new work in the Prevention of Mother–to-Child Transmission of HIV (PMTCT). In addition, the presidential International Mother and Child HIV Prevention Initiative and the Emergency Plan for AIDS Relief had sparked interest in the PRIME II Project as a mechanism for USAID missions to access technical assistance to build the capacity of providers working in HIV/AIDS. PRIME quickly mobilized to create an HIV/AIDS Integration with Family Planning Global Team and craft a short-term strategy to demonstrate the benefits of using PI approaches for providers working in FP/RH and HIV/AIDS. We have linked with the PI Global Team to incorporate HIV content into non-training interventions in Year 5 and collect lessons learned from the Philippines to Armenia and Rwanda on PRIME's experiences building human capacity to deal with the AIDS pandemic. HIV/AIDS will be a priority for PRIME II for the remainder of the Project.

At about the same time as PRIME's decision to expand work in HIV/AIDS, and as a result of both accomplishments and challenges facing the Consumer-Driven Quality (CDQ) TLA, the CDQ Global Team agreed that it was time to assess the TLA's path for the future. A CDQ "think tank" reviewed the history and strategy of the TLA, discussed the details of its niche, and outlined successes and challenges to date. PRIME's CDQ effort has a lengthy set of accomplishments (see TLA Question) including a fully developed three-pronged strategy, four almost completed projects that will yield measurable and significant results, a detailed brochure ready to be printed in three languages, selection as one of three projects presented at the USAID annual Results Review in 2002, acceptance of three presentations at the APHA meeting in 2003, leadership in the MAQ/CDQ Subcommittee, and an active Global Team crossing partners and regions.

However, the CDQ TLA had also confronted some challenges including changes in co-chair leadership and a prolonged period of developing a conceptual framework and tools.

Consequently, country-specific interventions were put in place relatively late in PRIME. At the same time, scholars and PI practitioners had advocated that the PI approach should incorporate consumer perspectives in order to help set more realistic and client-oriented performance expectations for health providers.

To best scale-up and sustain PRIME's CDQ strategy and approaches, the think tank group thus recommended:

Integrating the CDQ TLA into the PI TLA

- Ensuring CDQ representation on the PI Global Team
- Ensuring the CDQ budget and workplan maintain their integrity within the PI TLA
- Ensuring CDQ representation on the new HIV/AIDS Integration with Family Planning Global Team
- Continuing to have a dedicated CDQ staff person in Chapel Hill
- Changing the name Consumer-Driven Quality to Integrating Consumer Perspectives (ICP) to better reflect PRIME's strategic approach as well as to reduce confusion with the MAQ Community-Driven Quality initiative.

The following statement, crystallized during the think tank meeting, reflects PRIME's intentions with ICP:

- ICP is an approach that enables providers to solicit and act on consumer perspectives to increase access to FP/RH services and improve the quality of FP/RH delivery at the primary level. The ICP approach includes processes, tools, methods and values.

Question 13. Based on your experience, how has IntraHealth functioned as a lead agency on the PRIME project? What are IntraHealth's strengths and weaknesses as a lead agency? How could they improve in this area?

IntraHealth International, with its 23 years of experience working in international health with primary providers, has been a highly effective lead agency for a large and complex global project. The simultaneous transition from UNC program to non-profit corporation during the implementation of PRIME II has only assisted IntraHealth to be a world-class leader in international public health. IntraHealth has corporate capacity with over 200 employees worldwide and a wide range of skills and competencies in health and education. The core team includes technical experts, seasoned managers and systems professionals who can work in different cultures, languages and currencies. IntraHealth's decentralized and diverse staff makes for an organization that is most responsive to the needs in countries where it works.

IntraHealth has taken its role as the lead of an inter-organizational partnership very seriously, working with partner organizations to create and maintain a fully functioning partnership. During the implementation of the PRIME I Project, a partnering model began to emerge that allowed a number of organizations to be involved successfully in a complex global undertaking. Based on that model, by the beginning of PRIME II IntraHealth had developed a compelling vision of how a partnership ought to function, and worked diligently and faithfully with partner organizations to ensure that this vision became a reality.

A key lesson learned in PRIME II is that effective leadership of a partnership requires constant attention and care. Even with institutions like the Partner Leadership Group (PLG) and its MOU's written principles of partnership, the demands and changing needs of a complex project frequently present challenging situations. IntraHealth brought particular strengths and learned lessons in the leadership role such as:

- A commitment to transparency and openness to discussion of issues with partner organizations maximizes effectiveness.
- Incorporation of partner staff in the leadership of PRIME's technical areas helped bring the technical strength of the various organizations to bear on the technical agenda of the Project.
- Even with quarterly Partner Leadership Group meetings, sometimes fast-moving events made it hard to keep the entire PRIME II community completely informed. IntraHealth set up special conference call sessions of the PLG between the quarterly meetings when circumstances warranted; at times, however, communications might have been better.
- During periods of work overload, redistribution of labor among partners probably could have been done more effectively.

Question 14. What has been PRIME's experience in recruiting and retaining staff during the life of the project? Address the changes in key personnel.

The PRIME II Project has experienced the good fortune of recruiting and retaining some of the most talented professionals in international reproductive health, along with experts in training innovation.

Because of the Project's success in attracting field support from USAID missions and our resulting rapid growth, timely recruiting and placement of staff in key positions has been of utmost importance, both in both headquarters and the field. Certain field assignments (such as hardship posts) were naturally more difficult to fill. However, the project has attracted committed professionals who, for the most part, have been well received by missions and country counterparts as effective leaders able to produce impressive results.

Some of the key personnel bid on the PRIME II cooperative agreement changed during the life of the project. One senior manager was offered a project director position elsewhere; another resigned after adopting a child. These positions were filled temporarily and have been refilled with permanent staff who bring many years of health, development and performance improvement experience. The biggest change, of course, was the transition of PRIME's director to leadership of the new non-profit organization, IntraHealth International. During the transition period, the Project identified a deputy director from the existing executive team, who acted as lead manager and point of contact with USAID on a day-to-day basis. Intrah was able to recruit—from a field of seasoned leaders in international health and development—a formidable successor to lead PRIME. PRIME benefits by continuing to work closely with the former project director and other key staff, including senior PRIME partners who have been members of the Partner Leadership Group from its inception.

Even though the anticipated end date for PRIME II is just one year away, IntraHealth regularly receives inquiries from highly qualified professionals who are interested in working on PRIME and joining the new IntraHealth organization. With its more flexible hiring and compensation structure, IntraHealth is responding to the changing needs of the Project in a more nimble way, and meeting field requests for state-of-the-art technical assistance more efficiently than ever.

Question 16. Provide the funding trends PRIME has experienced in terms of core, field support, bilateral and other funding over the life of the project. Describe the trends' impact on PRIME programming.

Over the life of the Project, PRIME II has implemented over 80 activities in 27 countries worldwide. These activities have been financed by core funds, field support, or by core special initiatives funds.

Total cumulative and projected obligations are 70 million dollars, 39 million in field support and 31 million in core. Earmarks for field support funds continue to be over 50% for Population with growing earmarks for Child Survival and HIV/AIDS, particularly in the East and Southern Africa Region. Four significant funding trends over the life of the Project impacted PRIME programming:

Postpartum Hemorrhage Initiative

In fiscal year 2002, 1.2 million in core (Safe Motherhood) was obligated for preventing postpartum hemorrhage activities in Mali, Benin and Ethiopia. This funding has allowed PRIME II to take on significant work that provided the Project with opportunities to strengthen family planning and other reproductive health areas. In Mali the funding of PPH activities is already leveraging other funds. Extension of PPH activities with new bilateral funds was included in several new procurements. The funding has also allowed PRIME to gain better technical recognition among the African Society of OB/GYNs (SAGO) and the International Federation of OB/GYNs (FIGO).

Large Field-Support Requests (over $700,000 annual obligations)

Missions have turned to PRIME to design and implement complex, multi-faceted FP/RH service delivery programs. The Project has the capacity to manage and administer such extensive programs, with a successful track record in Bangladesh, Paraguay, El Salvador, Armenia, Rwanda, Ethiopia and others.

HIV/AIDS

In Rwanda and Ethiopia, PRIME has embraced new opportunities to help service providers prevent mother-to-child transmission (PMTCT) of HIV. In Armenia, we are starting a new field-supported initiative to address STI prevention, with screening and treatment to reduce the risk of HIV infection. Modest core funding in FY 2003 allowed the Project to bolster integration of family planning in PMTCT sites. This funding trend signals recognition of the crucial role that the primary provider can play in the fight against HIV/AIDS, particularly as it is integrated with all aspects of reproductive health.

Complementarity

PRIME has demonstrated an ability to complement other USAID-funded activities, working well with bilateral projects at the country level (e.g., Mali, Benin, Kenya). In several countries the Project secured multi-year funding, written into the USAID missions' R4. These agreements facilitated PRIME's ability to engage in longer-term planning of activities and provided opportunities for meaningful evaluation and documentation of the Project's

effects. In a few cases, on the other hand, the Project's ability to continue receiving field support was hampered when missions developed a new country strategy and pursued bilateral rather than global projects.

Question 1. What components of the PRIME II Project would you like to see continued in the future? Would you make changes to the design of PRIME? If so, describe the changes.

Several components of the PRIME II Project that have worked well are described below. The design of the Project has not been problematic and the main features such as the partnership, flexible design and mechanism, and decentralized structure have worked well. USAID should consider continuing, and in some cases adapting these further, for future work.

Focus on Primary Providers

The PRIME Project's focus on primary providers is appropriate and important. The evidence is clear that both a broader definition of primary providers (including community-level providers, private-sector providers such as pharmacists, volunteers and others) and an expanded role for these providers is needed to address the growing demands for quality health care services. Pressures on the health care delivery system brought about by factors such as the HIV pandemic and the bourgeoning cohort of youth entering reproductive age will only amplify this need. Work on the primary level needs must continue, particularly promoting increased recognition, support and an expanded role for primary providers. This work should be undertaken by those who are familiar with primary providers and the common barriers to their optimal performance, and might include promoting licensing, higher salaries, the ability to run private practices for profit, improved benefits, improved facilities and other forms of recognition.

Performance Improvement Really Succeeds

Evidence continues to show that the PI approach is highly successful in improving provider performance and service delivery. Still, many agencies are looking for a "quick fix" and there are strong incentives for maintaining existing training programs, so many continue to use training alone as an intervention, without applying the PI approach to analyze performance problems. This situation indicates that there is more work to be done in scaling up the use of the PI approach and ensuring its sustainability, including learning more about the scale-up process and how the approach can be customized for use in different contexts.

The PI Approach is Content Neutral

Performance Improvement has been applied successfully to various technical areas such as family planning, STI and HIV, safe motherhood, and postabortion care. In the future, there is a critical need to broaden the application of PI to fields beyond family planning, which can offer critical support in meeting the demands of the HIV pandemic and the large number of youth entering reproductive age.

Consumer Feedback, Blended Learning and Non-Training Interventions

PRIME has achieved important learning about how to improve provider performance and quality service delivery through consumer feedback mechanisms, innovative and blended learning approaches (such as distance learning and self-directed learning), and non-training interventions (such as clear performance expectations, supportive supervision and provider

motivation). But there is more work to be done to take PI to the next level, especially in the areas of developing and documenting more experience on non-training interventions such as motivation and supportive supervision, human resource allocation, job satisfaction and employee retention.

Training's Central Role

Recognizing that training is an important and expensive intervention, PRIME has learned a great deal about how to make it more effective. Future work is needed to scale up the use of approaches that make training more effective and cost efficient, such as:

- Conducting performance needs assessments (PNAs)
- Implementing complementary training and non-training interventions as indicated by PNAs
- Applying the Performance Learning Methodology
- Planning innovative and blended learning
- Improving the use of information technology.

Question 2. Suggest changes to the management interface of PRIME and USAID that would promote communication, efficiency and enhance results.

As described in Management Question 9, the management interface with USAID has functioned well for the PRIME II Project.

Changes that would improve efficiency and enhance results include:

- Multiple year funding allocations would help significantly in project planning and implementation (see Management Question 8 for more on this).
- Consistent staff in the Cognizant Technical Office and/or Senior Technical Advisor positions, with the basic knowledge and skills to manage a large global FP/RH project. (Note: The USAID course for CTOs seems to be useful here).
- Shifting the balance from expectations for overly quick results toward more support for a sustainable, capacity-building approach.
- Increased understanding of the difficulties that a large project faces when asked to change significantly after its design and start-up.
- Increased communication between missions and USAID/W, aimed at working out conflicts of interest, and assistance in gaining mission support for the technical leadership inputs expected from a global technical leadership project.

APPENDIX F

PRIME II COUNTRY PROGRAMS BY REGION

PRIME II COUNTRY PROGRAMS BY REGION

WEST AND CENTRAL AFRICA

Country	Type of Project	Main Activities	Field Support or Core Funds	TLA(s) or Technical Area(s)	Average Annual Funding
Rwanda	FP/RH, gender	▪ Pre and inservice training (training) ▪ RH protocols (policy) ▪ PMTCT (policy, training) ▪ Mutuelles/ICP (PI)	Field Support and Core Funds	Gender, ICP (BCC/IEC/FP), HIV/AIDS, RTL, PI	$1,700, 000 (FS) $300,000 (Core Projects)
Ghana	FP/RH, safe motherhood/PAC	▪ Community-based planning/services: training and supervision ▪ LSS/PAC: self-paced learning and supervision	Field Support and Core Funds	PAC, RTL, PI, ICP	$1,100,000 (FS) $350,000 (Core Projects)
Benin	FP/RH/EONC	▪ Family health protocols/EONC (policy, training, PI) ▪ PPH and PAC (policy, training, PI)	FS (protocols) and Core Funds (PPH and others)	PI, RTL, PAC	$500,000 (FS) $300,000 (Core Projects)
Senegal	FP/RH, safe motherhood/PAC, PI supervision	▪ Developing and testing model to expand PAC/FP services at primary and community levels ▪ PI supervision of community health workers	Core Funds	PAC, PI	$350,000 (Total Core)
Guinea	Safe motherhood/EONC	▪ Safe motherhood training and community mobilization ▪ PI for immunizations (BASICS)	Core Funds	RTL, PI	$250,000 (Core)
Mali	Inservice training, female genital cutting, PPH, MAQ	▪ Increase quality of health care through improved and decentralized training systems ▪ Expand the role of the primary provider in the elimination of female genital cutting ▪ Preventing PPH	Field Support and Core Funds	RTL	$300,000 (FS) $300,000 (Core)
Nigeria	MAQ, PNA, PI	▪ Nigeria MAQ Exchange ▪ Performance factors special study ▪ Performance needs assessment to inform USAID strategy	Core Funds	PI	$240,000 (Total Core)

BCC:	Behavior change communication	LSS:	Life saving skills	PPH:	Postpartum hemorrhaging
EONC:	Emergency obstetric and neonatal care	MAQ:	Maximizing Access and Quality	RH:	Reproductive health
FP:	Family planning	PAC:	Postabortion care	RTL:	Responsive training and learning
FS:	Field support	PI:	Performance improvement	TLA:	Technical leadership area
ICP:	Integrated consumer perspectives	PMTCT:	Prevention of mother to child transmission		
IEC:	Information, education and communication	PNA:	Performance Needs Assessment		

EAST AND SOUTHERN AFRICA

Country	Type of Project	Main Activities	Field Support or Core Funds	Technical Leadership Area(s) or Technical Area(s)	Average Annual Funding
Kenya	FP, PAC	▪ Training ▪ Supervision	Field Support and Core Funds	RTL, PAC, PI	$150,000 (FS) $500,000 (Core)
Ethiopia	HIV/AIDS, FP, Safe Motherhood	▪ Training ▪ Supervision ▪ Capacity building ▪ Antenatal care ▪ Community linkages	Field Support and Core Funds	PI, safe motherhood, female genital cutting/female genital mutilation, community interventions	$2.5 Million (2003 FS Initiative)
Tanzania	FP, RH, Child Health	▪ Performance improvement ▪ Quality improvement of services/systems ▪ Capacity building of ZTCs, RCHS ▪ National policy guidelines ▪ Generate demand for RH services ▪ Program management support ▪ Training (PST/IST/OJT) and curricula development	Field Support	PI, human resources management, financial management, family planning and PAC, M&E	$800,000 (FS)
Zambia	FP/RH	▪ Consumer-oriented care ▪ Policies/standards for midwifery ▪ Comparison of learning approaches	Core Funds	Consumer-driven quality, integrated consumer perspectives	$150,000 (Core)
Uganda	Adolescent RH, PAC Family Planning Project	▪ Developed an adolescent RH expansion strategy in 11 health districts in coordination with the DISH II bilateral project ▪ Introduce a postabortion FP project to identify barriers to provision of counseling and service delivery	Core Funds	PI, RH, PAC	No PRIME II Field Support Proposed FY 2003 $190,000 Core Funding

FP:	Family planning	PI:	Performance improvement
FS:	Field support	PST:	Preservice training
IST:	Inservice training	RCHS:	Reproductive and Child Health Section
M&E:	Monitoring and evaluation	RH:	Reproductive health
OJT:	On-the-job training	RTL:	Responsive training and learning
PAC:	Postabortion care	ZTC:	Zonal training center

LATIN AMERICA AND THE CARIBBEAN

Country	Type of Project	Main Activities	Field Support or Core Funds	TLA(s) or Technical Area(s)	Average Annual Funding
Dominican Republic	FP/safe motherhood (FS), comparing learning approaches (Core), ICP (Core)	▪ Working with MOH, NGOs to improve RH and MH service delivery, including preservice training ▪ Test two approaches for training community promoters in FP ▪ Use consumer feedback to improve services at NGO clinic	Field Support and Core Funds	RTL, PI	$285,000 (FS) $450,000 (Core)
Nicaragua	Postpartum FP/safe motherhood (EOC), ICP	▪ Implemented community-based life saving skills methodology in Jinotega region ▪ Incorporate youth perspectives in the quality of RH services provided by 185 pharmacies in Managua	Field Support and Core Funds	RTL	$75,000 (FS) $300,000 (Core)
Honduras	PI, supportive supervision	▪ In coordination with the MOH, developed and implemented a new supportive supervision model to improve the performance of FP/RH providers in Olancho, Honduras	Core Funds	PI	$300,000
Paraguay	Improving access and quality of RH programs, improving maternal health care	▪ Variety of activities focused on improving quality, IEC, networks, and policy (evaluate and design new 5–year national RH plan) ▪ Improve providers' performance and knowledge regarding MH in Caaguazu region (both facility and community levels)	Field Support	Two new projects to be implemented in 2003–2004 in PI and RTL; small HIV component	$2,052,202 (FS: quality) $1,504,586 (FS: maternal health)
Bolivia	PI study	▪ Performance factor study of about 300 MOH auxiliary nurses who provide prenatal and FP services in the Altiplano (La Paz district)	Core Funds	PI	$60,000 (Core)
Haiti	Postabortion care	▪ Improve postabortion FP activities at one private and two public facilities	Core Funds	PAC	$145,000 (Core)

EOC:	Emergency obstetric care	NGO:	Nongovernmental organization
FP:	Family planning	PAC:	Postabortion care
FS:	Field support	PI:	Performance improvement
ICP:	Integrated consumer perspectives	PST:	Preservice training
IEC:	Information, education and communication	RH:	Reproductive health
MH:	Maternal health	RTL:	Responsive training and learning
MOH:	Ministry of Health	TLA:	Technical leadership area

EASTERN EUROPE/EURASIA

Country	Type of Project	Main Activities	Field Support or Core Funds	TLA(s) or Technical Area(s)	Average Annual Funding
Armenia	MCH, gender	▪ Training nurses at primary level ▪ Policy: integrating RH into health reform ▪ Gender: violence against women ▪ PI: supervision and community involvement	Field Support and Core Funds	PI, RTL, Gender, CDQ	$1,000,000 (FS)
Uzbekistan	RTL, MCH	▪ Learning package development for safe motherhood	Field Support	RTL	$150,000 (FS)
Kyrgyz Republic	Postabortion family planning, HIV/FP integration, PI/motivation	▪ Addressing barriers to postabortion FP in two rural areas ▪ Addressing motivation barriers to integrating HIV counseling into FP counseling	Core Funds	PAC, PI, HIV	$150,000 (Core)

CDQ:	Community-driven quality	PI:	Performance improvement
FP:	Family planning	RH:	Reproductive health
FS:	Field support	RTL:	Responsive training and learning
MCH:	Maternal and child health	TLA:	Technical leadership area
PAC:	Postabortion care		

ASIA AND MIDDLE EAST AND NORTH AFRICA (MENA)

Country	Type of Project	Main Activities	Field Support or Core Funds	TLA(s) or Technical Area(s)	Average Annual Funding
Bangladesh (Asia)	Technical assistance to the government of Bangladesh to implement national, decentralized inservice training for the Essential Services Package	▪ Establish management and coordination systems for the central level ▪ Standardize quality in inservice training/national training standards, guidelines, and curriculum development ▪ Strengthen the capacity of training organizations (e.g., performance needs assessment, curriculum development, and transfer of learning workshops) ▪ Strengthen district and subdistrict-level capacity and capability for implementation, monitoring and follow up of training, and supportive supervision ▪ Establish a database and TMIS at the central level and decentralize TMIS at the district level	Field Support	PI	$1,000,000 (FS)
India (Asia)	MCH and FP, Community Partnerships in Safe Motherhood	▪ Capacity building for NGO and public sector training organizations ▪ Training of auxiliary nurse-midwives, traditional doctors, TBAs, community midwives (private sector) ▪ Use of HBLSS to train home-based providers to deal with obstetric emergencies ▪ Supportive supervision	Field Support; Core Funds (for future CPSM and ELM Project)	PI, RTL	$800,000 (FS/Core)
Philippines (Asia)	Dual protection for adolescents	▪ Counseling of adolescent sex workers on dual protection ▪ Development of counseling materials based on focus group findings	Core Funds	ICP	$120,000 (Core)
Yemen (MENA)	Improve the performance of community midwives and murshidaats, strengthen community midwives systems	▪ Designed a performance support system that incorporates elements of supportive supervision, inservice training, and a reward system ▪ Strengthen supervision and monitoring capacity of the health offices in identified governorates ▪ Map current locations and identify estimated coverage of approximate 120 CMWs in the five target governorates ▪ Identify performance needs of both CMWs and supervisors and determine appropriate activities; collect and use data	Earmarked Core Funds	PI	$100,000 (Earmarked Core)

CMW:	Community-level, private-sector midwives	NGO:	Nongovernmental organization
CPSM:	Community Partnerships in Safe Motherhood	PI:	Performance improvement
FP:	Family planning	RTL:	Responsive training and learning
HBLSS:	Home-based life saving skills	TBA:	Traditional birth attendant
ICP:	Integrating consumer perspectives	TMIS:	Training management information system
MCH:	Maternal and child health	TLA:	Technical leadership area

APPENDIX G

SUMMARY OF RECOMMENDATIONS

SUMMARY OF RECOMMENDATIONS

PROVIDER PERFORMANCE IMPROVEMENT AND OTHER TRAINING INTERVENTIONS

PRIME II should develop a streamlined marketing tool to outline the steps and successes of the performance needs assessment process that can be shown to ministries of health in other countries that are requesting training.

PRIME II needs to continue to work on training strategies that not only meet the needs to upgrade technical skills and knowledge, but that also have low cost requirements in terms of resources and staff time to further sustainability.

PRIME II should continue to develop approaches that can be used effectively in low-resource settings. Some approaches, such as self-paced learning, may be more useful for settings requiring time flexibility for staff learning but there also need to be methods for assuring that the individual learning approach is appropriate for the learners.

PRIME II should prepare materials and conduct briefings among stakeholders of self-paced learning to inform them of the results and to identify ways to continue using this learning strategy.

PRIME II is urged to explore methods for controlling timing for some of the self-paced learning methods and to develop better tools for evaluating the effects of the variety of blended learning approaches that have been developed for various country situations.

PRIME II should be encouraged to maximize the involvement of individuals with technical expertise in the production of instructional materials on each curriculum development team so that the materials are easier to use in terms of the amount and type of printed matter, the use of illustrations, and similar issues concerning the format used for presentation. The materials need to be thoroughly pretested among the target audience to ensure that they are appropriate and usable.

PRIME II should explore alternate methods for making evidence-based best practice materials available to primary care providers. One possible strategy is for the regional offices and the Headquarters Training and Learning Unit to gather evidence-based literature regarding best practices on the problems that most concern primary care practitioners in their regions and deliver this information in an accessible format through the country offices.

PRIME should consider compiling a sourcebook detailing the effective strategies that it has used to enhance provider performance. Drawing on PRIME's experience, the document should outline key steps to follow and alternative steps that can be taken depending on the circumstances and results at various stages in the process. It should include examples as well as lists of CAs and other organizations that can assist in addressing management support needs.

Clinical Training Sites

PRIME II should promote the sustainability of training sites by incorporating a time line with buy-ins from host country institutions, CAs, and/or NGOs for assuming responsibility for the follow-on activities of continued educational support and materials supply.

Supportive Supervision

PRIME II should continue to develop alternative posttraining support strategies, such as peer-group supervision.

Monitoring and Evaluation

PRIME II should continue in a leadership role in the monitoring and evaluation community in the ongoing effort to determine criterion-referenced standards of provider performance and methods/procedures for measuring these outcomes.

THE FUTURE FOR PRIME II

PRIME II should continue to develop partnerships with local and international community development organizations to increase local awareness and generate demand for PRIME–supported quality services.

PRIME II should immediately initiate actions that promote the development of systems that can be left in place to support and sustain training efforts implemented during PRIME II.

In each country in which PRIME II is currently engaged in activities in support of policy development, PRIME II should take steps to ensure that this important process continues.

In areas where PRIME II is involved in training community health workers, it should explore mechanisms to assure that these workers will continue to receive new training and updates so that they can continue to feel empowered to perform their jobs.

PRIME II should be encouraged to write a manual on the care and nurturing of a partnership. The manual should emphasize the critical aspects of a partnership, including agreements of methods of work as well as the procedures established to settle conflict. The partnership memorandum of understanding should be included in this manual. The manual should be made available through USAID/Washington to all partners and those in partnership agreements.

PRIME II should be encouraged to incorporate a cost/results analysis for the majority of its learning approaches and nontraining interventions.

PRIME II should be encouraged to compile the lessons learned using the performance improvement approach and to disseminate the document to all organizations involved in training.

PRIME II should maximize opportunities to disseminate the results of its strategies and outcomes. Presentations at global health forums and publication in the peer-reviewed literature are encouraged.

PRIME II recently added HIV/AIDS as a new technical leadership area. HIV/AIDS is becoming an increasingly important activity in PRIME II, representing about 9.7 percent of funding overall and 30.8 percent in the fifth year of the project. PRIME has much to bring to this important new programming area that could help to rationalize programming in this challenging and challenged arena. **PRIME should continue its work in integrating HIV/AIDS and RH services but should strive to achieve a balance and not let HIV/AIDS detract from other important RH activities.**

THE FUTURE FOR USAID/WASHINGTON

USAID/Washington should study carefully the factors that made PRIME II work so well and attempt to replicate them in future procurements.

The methodologies developed through the project, especially the performance improvement approach in all of its facets, should be continued through other efforts in training supported by USAID/Washington.

USAID/Washington should consider ways to ensure that USAID intermediaries, such as PRIME, have sufficient time in-country to maximize their potential impact.

USAID/Washington should find ways to ensure that PRIME's unique and valuable contribution to monitoring and evaluation is not lost after the present CA terminates.

To the degree possible within existing funding constraints, USAID/Washington should strive to ensure an adequate level of core funding in future procurements of this type to provide for the benefits described above and should monitor the use of such funds carefully to ensure their effective use.

USAID/Washington should reconsider its decision to end this initiative with PRIME in September 2004, particularly as there appear to be no ready alternatives to provide this type of assistance. Performance improvement and comparable training work with primary providers is not being performed systematically in other CA programs. The new ACQUIRE project does not appear to be written to continue this important work (even though a large percentage of its funding is for "improved performance of service delivery providers" and "strengthened environment for RH/FP service delivery" and even though IntraHealth is a partner in ACQUIRE). The loss of the PRIME II partnership and all of the skills each partner brings will limit the effectiveness of ACQUIRE to provide the performance improvement, performance needs assessment, and supportive supervision approach. Even where Missions decide to continue PRIME activities, the timing problems attendant to bilateral projects and Leader With Associates contracts (including the need to have Mission contracting officers in agreement) will almost certainly mean that some key PRIME activities will have to terminate before realizing their maximum potential.

Changes to the basic project design are not recommended. The project is successful as is; there is no reason to change it.

For continuity as well as to maintain excellent communication, the CTO should remain the same.

APPENDIX H

PERFORMANCE FACTORS BY PROJECT FOR PRIME II

PERFORMANCE FACTORS BY PROJECT FOR PRIME II

Country	PRIME II Projects	Skills and Knowledge	Clear Performance Expectations	Performance Feedback	Physical Environment and Supplies	Motivation	Total Number of Factors
Asia							
Bangladesh	Technical assistance for implementation of the national inservice training strategy for the essential health package (NIPHP)	✓		✓			2
	Health and Population Sector Programme (HPSP)	✓	✓	✓			3
	Development of the national inservice training strategy for the government		✓		✓		2
India	Clinic-based family planning training of auxiliary nurse-midwives in Uttar Pradesh	✓		✓	✓		3
	Skill-based training of traditional birth attendants	✓		✓	✓		3
	Reproductive and child health services through community midwives	✓	✓			✓	3
	Indigenous systems of medicine and homeopathy training program	✓		✓	✓		3
	Postabortion care community assessment (study; finished)	✓					1
	Community Partnerships in Safe Motherhood (final evaluation completed)	✓	✓		✓		3
	Performance learning methodology						
	Community-level outreach for emergency obstetric and neonatal care						
	Training institutionalization program	✓					1
Philippines	Dual protection outreach for adolescents	✓			✓		2

Country	PRIME II Projects	Skills and Knowledge	Clear Performance Expectations	Performance Feedback	Physical Environment and Supplies	Motivation	Total Number of Factors
East and Southern Africa							
Ethiopia	Preventing postpartum hemorrhaging	✓	✓				2
	Female genital cutting	✓					1
	Prevention of mother-to-child transmission (PMTCT)	✓	✓		✓		3
Kenya	Postabortion care phases I and II	✓	✓				2
	Postabortion care expansion phase III	✓	✓		✓		3
	Eliminating female genital cutting	✓	✓				2
	Strengthening supervision: developing peer support for primary providers		✓	✓		✓	3
	Reducing barriers to condom promotion by family planning providers	✓					1
	Interactive Simulation Project	✓					1
	Special study to determine a package of priority reproductive health services for private nurse-midwives to offer women treated for abortion complications						
	Postabortion care sustainability						
	Performance improvement short course and targeted follow up	✓	✓				2
Tanzania	Quality Improvement Recognition Initiative	✓	✓		✓		3
Uganda	Postabortion Family Planning Initiative						
	Regional initiative with the Regional Center for Quality Health Care	✓			✓		2
	Ensuring provision of adolescent friendly services in Jinja District	✓					1
	Performance improvement short course and targeted follow up	✓			✓		2
Zambia	Using consumer perspectives on service quality to develop family practice/reproductive health practice standards	✓	✓				2
East and South Africa Regional Initiative	East, Central, and Southern Africa College of Nursing	✓	✓				2

Country	PRIME II Projects	Skills and Knowledge	Clear Performance Expectations	Performance Feedback	Physical Environment and Supplies	Motivation	Total Number of Factors
Eastern Europe and Eurasia							
Armenia	Performance factors special study						
	Improving primary reproductive health providers' response to gender-based violence	✓					1
	Improving the quality of maternal and newborn care	✓	✓		✓		3
	HIV/STI	✓					1
	Sustainable, provider-centered supervision systems	✓					1
Kyrgyz Republic	Increasing use of family planning by women receiving postabortion care (phase I)						
	Increasing use of family planning by women receiving postabortion care (phase II) (will start September 2003)	✓	✓				2
	Provider motivation and incentives					✓	1
Uzbekistan	Maternal and child health competency-based learning package for primary care providers (completed)	✓	✓				2
Latin America and the Caribbean							
Bolivia	Performance factors special study						
Dominican Republic	Strengthening NGO reproductive health programs	✓			✓		2
	Distance-learning project/comparing learning approaches, phase I	✓	✓		✓		3
	Community-defined quality assistance to NGO FP/RH clinic	✓		✓			2
	Performance improvement second follow-up study						
El Salvador	Salvadoreños Saludables (SALSA)	✓			✓		2
Haiti	Postabortion care						
Honduras	Linking performance improvement with health sector reform	✓	✓	✓			3
Nicaragua	Postpartum FP and emergency obstetric and neonatal care	✓	✓				2
	Youth and pharmacists	✓	✓				2
	Integrating Consumer Perspectives (ICP)			✓			1
Paraguay	Improving maternal health	✓	✓				2
	Quality and accessibility of reproductive health care	✓	✓		✓		3
	Performance improvement performance feedback			✓			1
LAC Regional Project	Linking the Maximizing Access and Quality model						

Country	PRIME II Projects	Skills and Knowledge	Clear Performance Expectations	Performance Feedback	Physical Environment and Supplies	Motivation	Total Number of Factors
Middle East and North Africa							
Yemen	Community midwife program	✓	✓				2
	Strengthening the performance of community midwives in Yemen	✓					1
West and Central Africa							
Benin	Emergency obstetric and neonatal care	✓	✓		✓		3
	National family planning/reproductive health protocols	✓	✓		✓		3
	Postpartum hemorrhaging	✓	✓		✓		3
	Family planning training for pharmacists	✓					1
	Clear performance expectations		✓				1
	Francophone postabortion care	✓	✓		✓		3
Ghana	Community-based health planning and services	✓	✓				2
	SPL/postabortion care scale up	✓	✓	✓	✓	✓	5
	Training system capacity building	✓	✓				2
Guinea	Safe motherhood	✓	✓		✓		3
	Performance improvement for immunizations for BASICS	✓			✓		2
Mali	National Inservice Training Strategy (NIST)	✓	✓				2
	Expanding the role of the provider in eliminating female genital cutting	✓					1
	Postpartum hemorrhage	✓	✓		✓		3
	Maximizing Access and Quality Exchange						
Nigeria	Performance Factors Special Study						
	Performance Needs Assessment (to inform USAID strategy)	✓	✓	✓	✓	✓	5
	Maximizing Access and Quality Exchange						
Rwanda	Health financing and decentralization: Mutuelles, community-driven quality/Partenariat pour l'amélioration de la Qualité (PAQ)						
	Reproductive health/policy standards	✓	✓				2
	PMTCT	✓	✓		✓		3
	Family planning integration in prevention of mother to child transmission special initiative	✓	✓				2
	Quality of care: inservice and preservice training	✓	✓	✓			3
	Information, education and communication/behavior change communication/family planning	✓					1
	Gender sensitivity assessment tools evaluation	✓					1

Country	PRIME II Projects	Skills and Knowledge	Clear Performance Expectations	Performance Feedback	Physical Environment and Supplies	Motivation	Number of Factors
West and Central Africa							
Senegal	Family planning/postabortion care	✓			✓	✓	3
	Supervision of community health workers						
	Performance improvement short course						
WCA Regional Initiative	Francophone postabortion care conference						
TOTAL		**63**	**40**	**13**	**27**	**6**	
Project Average (average includes only projects with one or more factors)							**2.16**

APPENDIX I

SUMMARY OF PRIME II FUNDING TO DATE

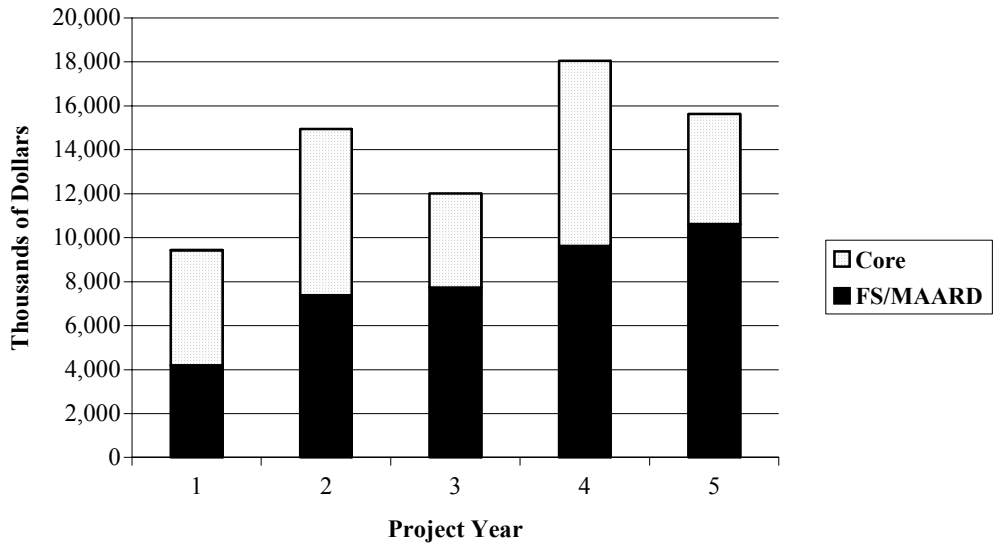
SUMMARY OF PRIME II FUNDING TO DATE

Figures for the fifth project year reflect funding already in place for activities through September 2004, except for field support (FS)/MAARD funding, which is projected through June 2004.

Summary of PRIME II Funding to Date

Type of Funding	Project Year 1	Project Year 2	Project Year 3	Project Year 4	Project Year 5	TOTAL
FS/MAARD	4,190	7,380	7,728	9,617	10,604	**39,519**
Core	5,250	7,560	4,285	8,427	5,020	**30,542**
TOTAL	**9,440**	**14,940**	**12,013**	**18,044**	**15,624**	**70,061**

PRIME II Funding Summary

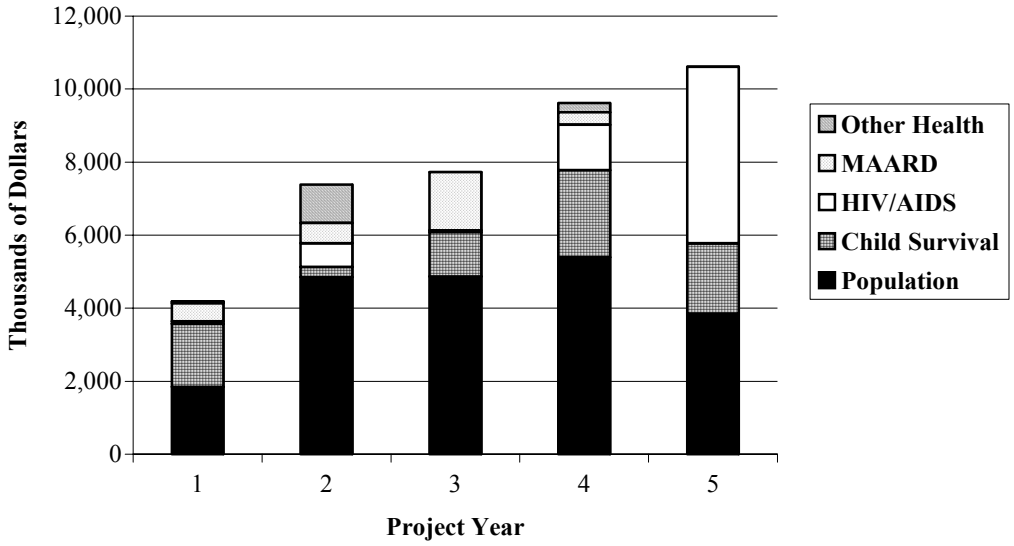


PRIME II FIELD SUPPORT/MAARD FUNDING BY TYPE AND YEAR

Funding by Type and Year

Type of Funding	Project Year 1	Project Year 2	Project Year 3	Project Year 4	Project Year 5	TOTAL
Population	1,851	4,855	4,873	5,394	3,854	**20,827**
Child Survival	1,723	275	1,205	2,381	1,925	**7,509**
HIV/AIDS	70	650	50	1,250	4,825	**6,845**
MAARD	500	550	1,600	342	0	**2,992**
Other Health	46	1,050	0	250	0	**1,346**
TOTAL FS/MAARD	**4,190**	**7,380**	**7,728**	**9,617**	**10,604**	**39,519**

PRIME II FS/MAARD Funding



OTHER FUNDING FOR ACTIVITIES SIMILAR TO THOSE OF PRIME II

In addition to funding directly received under the PRIME II cooperative agreement, it is estimated that approximately $9–10 million has already been committed under bilateral organizations, other contracts, and through other donors for activities similar to those of PRIME II (n=8) (i.e., activities that can reasonably be seen to have resulted from work under the PRIME II cooperative agreement).

SPECIAL INITIATIVES FUNDING
(US $)

Work Plan Year	Adolescents	Birth-spacing	FGC	Gender	Gender-Based Violence	HIV/AIDS Integration	MAQ	NGO Networks	PAC	PI	Maternal Health (SO 2)	PPH (SO 2)	Venture Capital	Total Funding
Year 1 (January 2000–February 2001)[1]		✓	✓	✓	✓	✓	✓				210,000			**1,690,000**
Year 2 (March 2001–June 2002)	100,000		65,000			100,000	150,000		100,000	50,000	220,000			**785,000**
Year 3 (July 2002–June 2003)	40,000		100,000	100,000			125,000	200,000			200,000	1,200,000	300,000	**2,265,000**
Year 4 (July 2003–September 2004)			150,000	80,000		150,000	40,000				200,000			**620,000**
TOTAL	**$140,000**		**$315,000**	**$180,000**		**$250,000**	**$315,000**	**$200,000**	**$100,000**	**$50,000**	**$830,000**	**$1,200,000**	**$300,000**	**$5,360,000**

[1]Specific Special Initiatives were not recorded by amount in this period (except for SO 2 maternal health versus population funding), although the ✓ indicates that funds were spent.

Figures are based on work plan budget figures, not actual expenditures.

FGC: Female genital cutting	PI: Performance improvement
MAQ: Maximizing Access and Quality	PPH: Postpartum hemorrhaging
NGO: Nongovermental organization	SO: Strategic Objective
PAC: Postabortion care	

APPENDIX J

EXAMPLES OF EXPECTED RESULTS FROM CONTINUED PRIME II WORK

EXAMPLES OF EXPECTED RESULTS FROM CONTINUED PRIME II WORK

ARMENIA

The 2003–04 budget is $1.2 million in field support funds, complemented by core funds.

PRIME began work in 2001, contributing to a new national law and policies on reproductive health (RH) and rights and helped to establish the framework for new RH service protocols. Using a performance improvement approach, PRIME is working with the Ministry of Health (MOH) to improve the performance of primary care providers in maternal and child health (MCH), sexually transmitted infections (STIs), and family planning (FP).

The ability to continue work for another year or two would result in

- more rapid sector reform in rural Armenia and movement to a primary health care model with fully integrated RH services at every level of the primary care system;
- an expanded model of primary care in the most remote health facilities whereby
  - nurses and midwives offer basic maternal and infant care and routine preventative services and are effectively linked to referral facilities,
  - facilities have basic equipment and supplies necessary to do their jobs,
  - communities work together with providers to improve quality and access to care, and
  - supervisory systems support strong performance at the first line of care in rural areas;
- strengthened national inservice and preservice training capacity in RH for obstetricians, family physicians, and primary care nurses and midwives, including strong clinical faculty and preceptors, an increased number of high quality clinical practice sites, and nationally approved clinical training modules;
- increased access to higher quality integrated STI services at the primary level;
- development and translation of national polices into clear provider performance expectations; and
- expansion of a successful effort to improve provider ability to treat and refer women experiencing domestic violence, which is a serious problem in Armenia.

BENIN

The 2003–04 budget is $500,000 in field support funds, complemented by significant core funding for the prevention of postpartum hemorrhaging and clear performance expectations.

In Benin, PRIME II is the principal mechanism through which USAID offers technical assistance to the central level MOH. PRIME II has helped the MOH to strengthen its training capacity and expand the FP/RH service delivery network of primary providers. To ensure the sustainability of training interventions, PRIME II has worked with the MOH to ensure that the health system is equipped with trainers at all levels, national standards, and training curricula adopted by the MOH and used by USAID–funded partners as well as other partner agencies. USAID/Benin's current country strategic plan continues through September 2005; the Mission has expressed interest in continuing to support PRIME II's work beyond September 2004.

The ability to continue work for another year in Benin would result in

- assistance to the MOH in implementation of the national plan to introduce and support postabortion care (PAC) services at various levels of the health care system;
- updated national polices, norms, and procedures to further integrate HIV/AIDS, prevention of postpartum hemorrhaging, and other new elements;
- development of clear performance expectations that are linked to national policies and standards for primary providers;
- improved quality of RH services, especially emergency obstetrics, PAC, postpartum hemorrhaging, and neonatal care at the health facility and community level;
- reduced incidence of female genital cutting as a result of support to providers in prevention and treatment of female genital cutting;
- updated curriculum for the Master's in Public Health degree program done in collaboration with the Regional Public Health Institute (Institut Régional de la Santé Publique); and
- strong community-based health financing (mutuelles de santé) in collaboration with PHR*plus*.

PARAGUAY

The 2003–04 budget is $1.1 million in field support funds, complemented by core funds for a comparative feedback project.

PRIME II began work in 2002 on a comprehensive effort to improve the quality of RH services at the primary level, which included work from the policy to the community level. PRIME II led an effort to evaluate and strengthen the national RH plan by participating in updating national policies and working to build linkages between service providers and community committees.

The ability to continue work for another year or two would result in the

- translation of new national policies and plans into clear performance expectations, provider protocols, and supportive supervision systems;
- sustainability of the quality of care in 23 sites of the quality project and the 11 sites of the maternal health project;
- use of the new referral and counter-referral systems;
- creation of stronger consumer groups that advocate higher quality services; and
- sustainability of the gains made in improving access to FP and RH services, including emergency obstetric care and surgical contraception.

EL SALVADOR

The 2003–04 budget is $1 million in field support funds.

PRIME II has worked in El Salvador for four years at a national level to enhance primary-level family planning and maternal health services. These efforts have included working with partners to improve contraceptive logistics.

The ability to continue work for another year or two would result in

- increased use of services by adolescents following the expansion of a successful pilot project geared specifically to adolescents;
- higher percentage of deliveries attended by skilled personnel;
- replication of obstetric emergency and PAC service delivery improvements;
- increased couple year protection due to increased access at the primary level, including through traditional birth attendants; and
- improved management of the logistics system and distribution of FP methods.

ETHIOPIA

The 2003–04 budget is $2.5 million in field support funds.

PRIME II's work in Ethiopia, which just began in 2003, focuses on developing national capacity to improve services for the prevention of mother-to-child transmission (PMTCT) of HIV.

The ability to continue work for another year or two would result in

- improved MCH, HIV, and FP services with stronger links between the services;
- sustained decreases in new pediatric HIV infections;
- increased use of FP, specifically by HIV–positive women;
- a more sustainable supportive supervisory system;
- a functioning community outreach system to increase use of integrated prenatal and PMTCT services; and
- a sustainable health management information system.

OTHER OPPORTUNITIES

Other opportunities were noted by the team, including in Ghana where the government is intent on a massive expansion of impact of PRIME II–supported activities, and in Bangladesh, where continued PRIME II assistance could be of great value to the government (providing that USAID/Dhaka reviews its decision not to support government programs). PRIME II is currently reviewing all of its field activities in order to identify continuing assistance needs.

The following chart shows PRIME II's anticipated results for the final year of the project.

ANTICIPATED RESULTS FOR THE LAST YEAR OF PRIME II

Country	PRIME II Projects	Date of Expected Results	Source of Funding	Key Achieved/Anticipated Results
Asia				
India	Reproductive and child health services through community midwives	April 1, 2004	Field Support	▪ Number/percent of community midwives performing to standard
	Indigenous systems of medicine and homeopathy training program	March 1, 2004	Field Support	▪ Qualitative study found increased motivation among indigenous systems of medicine selling contraceptives ▪ 96 percent of the 5,405 indigenous systems of medicine followed up performed to standard
	Performance learning methodology (PLM)	July 1, 2004	Core	▪ Determine the ability of developers to use the methodology and tools to develop/adapt curricula and create more effective and efficient training interventions ▪ Assess the effects of the PLM on the curricula and training to evaluate the usability of the PLM guide and tools ▪ Assess the effects on learner achievement during the implementation of the PLM–guided training intervention and compare costs of the current and PLM–guided interventions
	Community-level outreach for emergency obstetric and neonatal care	July 1, 2004	Core	
	Training institutionalization program	July 1, 2004	Field Support	▪ Increased training capacity of NGO training organization
Philippines	Dual protection outreach for adolescents	July 1, 2004	Field Support	▪ Improved counseling of teenagers by community health outreach workers ▪ Increased use of condoms and contraception by target adolescents
West and Central Africa				
Benin	Performance improvement: clear performance expectations	March 1, 2004	Core	▪ Improved performance expectations for priority services ▪ Improved provider performance ▪ Increased volume of services provided
	Emergency obstetric and neonatal care (EONC)	March 1, 2004	Field Support	Pilot is finished. Results include ▪ Improved provider performance in EONC ▪ Created/disseminated standards and protocols ▪ Improved training capacity ▪ Developed a feedback system ▪ Updated job descriptions

Country	PRIME II Projects	Date of Expected Results	Source of Funding	Key Achieved/Anticipated Results
Ghana	Self-paced learning (SPL)/PAC expansion	January 1, 2004	PAC/responsive learning and training, Core	▪ Most learners demonstrated competency ▪ There is a high level of satisfaction with the SPL approach, which suggests that provider performance has improved ▪ Regions report that safe motherhood recordkeeping has improved ▪ Learners can identify complications in pregnant women ▪ Learners have improved their management of complications and skills in appropriate referral
	Community-based health planning and services (CHPS)	September 1, 2004	Field Support	▪ Improved provider performance and capacity building ▪ Groundbreaking district cost analysis
Mali	National inservice training strategy	June 1, 2004	Field Support	▪ Developed capacity of trainers ▪ Developed and standardized training curricula ▪ Created national inservice training strategy/policy
Rwanda	RH policy standards	July 1, 2004	Field Support	▪ Created and disseminated RH policy standards (national RH policy signed in July 2003)
	PMTCT	July 1, 2004	Field Support	▪ Increased integration of HIV counseling and testing into prenatal care ▪ Increased number/percent of women counseled and tested during prenatal care
	Quality of care: inservice and preservice training	July 1, 2004	Field Support	▪ Improved provider performance in RH
	Gender sensitivity assessment tools evaluation	July 1, 2004	Core	▪ Increased male partner attendance at prenatal care/PMTCT consultations
Rwanda/Ethiopia	PMTCT/FP integration in a PMTCT special initiative	June 1, 2004	Field Support/Core	▪ A technical package, including an approach to improving the integration of FP in PMTCT service settings, tested in two countries in Sub-Saharan Africa and ready for use in other presidential initiative countries
Senegal	FP/PAC	April 1, 2004	Core	▪ Improved provider performance in recognition of danger signs ▪ Referral of pregnancy and abortion complications ▪ Counseling and provision of FP/PACFP methods ▪ Increased client acceptance of FP
	Supervision of community health workers	January 1, 2004	Core	▪ Number/percent of supervisors performing to standard ▪ Number/percent of providers receiving support from their supervisors ▪ Created and applied supervision tools

Country	PRIME II Projects	Date of Expected Results	Source of Funding	Key Achieved/Anticipated Results
East and Southern Africa				
Ethiopia	PMTCT	April 1, 2004	Field Support	▪ Completed such activities as site and community assessment and development of in-country partnership
		September 1, 2004	Field Support	▪ Improved capacity of sites to deliver PMTCT services ▪ Improved provider performance
	Female genital cutting	July 1, 2004	Core	▪ Improved provider performance in anti–female genital cutting counseling of clients
Tanzania	Quality Improvement and Recognition Initiative (QIRI)	June 1, 2004	Field Support	▪ Improved provider performance in PAC, infection prevention, RH services, and FP counseling ▪ Increased use of FP services by clients ▪ Improved support capacity of zonal training centers ▪ Improved service quality (physical environment and infection prevention) in QIRI–certified facilities ▪ Trained zonal training center staff in costing, pricing, and marketing
Uganda	Postabortion FP Initiative	January 1, 2004	Core	▪ Improved understanding and recommended interventions to increase accessibility, acceptability, and use of postabortion FP
Kenya	Reducing barriers to condom promotion by FP providers	July 1, 2004	Core	▪ Improved provider performance in condom/dual protection counseling
	Strengthening supervision: developing peer support for primary providers	April 1, 2004	Core/Field Support	▪ Improved provider performance in HIV/FP integration ▪ Established formalized peer support networks ▪ Costing of peer support
	PAC Sustainability Study	February 1, 2004	Core	▪ Identification of key factors that contribute to sustainability of private sector PAC services ▪ Recommendations for more sustainable private sector PAC services with implications for future expansion
	Interactive Simulation Project	May 1, 2004	Core	▪ Demonstrated feasibility of the DVD as a training tool ▪ Demonstrated provider learning and provider acceptance
Eastern Europe/Eurasia				
Armenia	Improving primary RH providers' response to gender based violence	June 1, 2004	Core	▪ Improved provider performance in gender violence recognition and referral for treatment
	Sustainable provider-centered supervision systems	May 1, 2004	Core	▪ Improved provider performance ▪ Improved supportive supervision practices

Country	PRIME II Projects	Date of Expected Results	Source of Funding	Key Achieved/Anticipated Results
Kyrgyz Republic	Increasing use of FP by women receiving PAC	May 1, 2004	Core	▪ Increased accessibility, acceptability, and use of postabortion FP ▪ Improved provider performance
	Provider motivation and incentives	March 1, 2004	Core	▪ Nontraining intervention testing the impact of public posting of performance data on provider performance in sexually transmitted disease/FP counseling integration
Latin America and the Caribbean				
El Salvador	Salvadoreños Saludables Project (SALSA)	February 1, 2004	Field Support	▪ Improved provider performance and quality of care ▪ Improved prenatal service delivery ▪ FP knowledge among clients ▪ Client perception of adolescent-friendly services ▪ Retrospective study of PAC services
Haiti	Increasing use of FP by women receiving PAC	January 1, 2004	Core	▪ Improved understanding and recommended interventions to increase accessibility, acceptability, and use of postabortion FP
Nicaragua	Youth and pharmacists/Integrating Consumer Perspectives (ICP)	April 1, 2004	Core/Field Support	▪ Baseline assessment of pharmacists' youth orientation
Paraguay	Quality Project	July 1, 2004	Field Support	▪ Improved provider performance for safe motherhood
	Performance improvement performance feedback and ICP	March 1, 2004	Core	▪ Report on monitoring data concerning feedback meetings on March 1, 2004
		June 1, 2004	Core	▪ Final evaluation of the effects of two feedback mechanisms on provider performance
Joint Multicountry Projects				
Ethiopia, Benin, Mali	Preventing postpartum hemorrhaging	February 1, 2004	Core	▪ Improved provider performance and quality of care in active management of the third stage of labor
Armenia, Nigeria, and Bolivia	Performance Factors Special Study	January 1, 2004	Core	▪ Quantification of correlation between presence of performance improvement factors and provider performance

Source: PRIME II. Some editing was done by the evaluation team.

APPENDIX K

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REFERENCES

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